Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.6

Includes Changes Implemented through January 2019

Submitted by:

Submission Date:	

CMS Receipt Date *(CMS Use)*	

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

Significant changes to the approved waiver that are being made in this renewal application include the following:

- Adding slot capacity.
- Adding a telehealth delivery option for a set of waiver services.
- Increasing flexibility for assessments, service planning, and case management to occur remotely/via telehealth by removing some references to specific modalities (i.e., “in person”, “telephone”) while maintaining operational integrity.
- Adding reassurances that providers that offer services via telehealth are following HIPAA requirements.
- Adding a unit rate for Partial Day – Day Services, in order to continue offering Day Services at less than a per diem rate, as authorized through Appendix K authority.
- Adding Assistive Technology as a new service.
- For many service providers, moving from annual to every two year verification of provider qualifications.
- Modifying language to reflect the fact that MFP Demonstration eligibility has been changed from 90 day to 60 day facility stay, which impacts ability of Demonstration participants to transfer to waivers if their initial facility stays were shorter than 90 days.
- Updating data sources and sampling approaches for several performance measures.
- Adding a description of how DDS utilizes Positive Behavior Supports.
- Updating language related to policies, training, and reporting requirements on restraints, restrictive interventions, and seclusion.
- Changing pronouns throughout to be gender neutral.

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE

HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors.

State:	
Effective Date	

1. Request Information

A. The **State** of **Massachusetts** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional – this title will be used to locate this waiver in the finder*): MFP Residential Supports (MFP-RS)

C. Type of Request: *(the system will automatically populate new, amendment, or renewal)*

Requested Approval Period: (*For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○	**3 years**
☑	**5 years**

☐	**New to replace waiver** Replacing Waiver Number:		
	Base Waiver Number:	MA.1028.R01.00	
	Amendment Number (if applicable):		
	Effective Date: (mm/dd/yy)		

D. Type of Waiver *(select only one)*:

○	**Model Waiver**
☑	**Regular Waiver**

E. Proposed Effective Date: 04/01/2023

Approved Effective Date *(CMS Use):*

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan *(check each that applies)*:

☑	**Hospital** *(select applicable level of care)*	
	☑	**Hospital as defined in 42 CFR §440.10** If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:
		Chronic and Rehabilitation Hospital, Psychiatric Hospital

	○	**Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160**
☑	**Nursing Facility** *(select applicable level of care)*	
	☑	**Nursing Facility as defined in 42 CFR §440.40 and 42 CFR §440.155** If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:
	○	**Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**
☐	**Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)** If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID facility level of care:	

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

☑	**Not applicable**
○	**Applicable**

Check the applicable authority or authorities:

☐	**Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**
☐	**Waiver(s) authorized under §1915(b) of the Act.** *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*

Specify the §1915(b) authorities under which this program operates (*check each that applies*):

☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)

☐	**A program operated under §1932(a) of the Act.** *Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:*
☐	**A program authorized under §1915(i) of the Act.**
☐	**A program authorized under §1915(j) of the Act.**
☐	**A program authorized under §1115 of the Act.** *Specify the program:*

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

☑	**This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

Goals and Objectives: The goal of the Massachusetts MFP Residential Supports Waiver (MFP-RS) is to transition eligible adults from nursing facilities, chronic or rehabilitation hospitals and psychiatric hospitals to qualified community settings providing 24 hour supports and to furnish home or community-based services to the waiver participants following their transition from the medical facility setting.

Organizational Structure: The Department of Developmental Services (DDS), a state agency within the Executive Office of Health and Human Services (EOHHS), is the lead agency responsible for day-to-day operation of this waiver. The Executive Office of Health and Human Services, the Single State Medicaid Agency, oversees DDS's operation of the waiver. DDS and the Massachusetts Rehabilitation Commission (MRC), a state agency within the Executive Office of Health and Human Services, collaborate in the oversight of the contracted Level of Care Entity and Administrative Service Organization.

Case Management and Service Delivery: Case Management for the MFP-RS waiver will be provided by staff of DDS. DDS will be responsible for participant needs assessment, service plan development and service authorization activities. Clinical determination of eligibility and level of care redetermination is conducted by nurses at the contracted Level of Care Entity. DDS will collaborate with MRC, a state agency within EOHHS, for the oversight of waiver clinical eligibility functions.

MFP-RS waiver services will be provided pursuant to a Plan of Care (POC) that is developed with the Waiver participant through a person-centered planning process. The POC is developed by an interdisciplinary team that is coordinated by the DDS Case Manager and includes the participant, ~~his/her~~their guardian if any, relevant waiver service providers, other persons as chosen by the participant and other appropriate professionals. The POC planning process will determine what MFP-RS waiver services, including their need for Residential Habilitation, Assisted Living Services or Shared Living - 24 Hour Supports services within the terms of the MFP-RS Waiver, and other supports that the waiver participant will need to live safely in the community.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. **Appendix A** specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. **Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. **Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. **Appendix D** specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. *(Select one)*:

☑	**Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
○	**No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. **Appendix F** specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. **Appendix G** describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. **Appendix H** contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. **Appendix I** describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. **Appendix J** contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

○	**Not Applicable**
☑	**No**
○	**Yes**

C. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

☑	**No**
○	**Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐	**Geographic Limitation**. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area*:
☐	**Limited Implementation of Participant-Direction**. A waiver of statewideness is requested in order to make ***participant direction of services*** as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state. *Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area*:

5. Assurances

In accordance with 42 CFR §441.302, the state provides the following assurances to CMS:

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services.

Appendix B specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR §440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem.

During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified throughout the application and in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

This section will be completed after the public comment period has ended.

The state held a public comment period for the four MFP and ABI waiver renewal applications from late September – late October, 2022 (exact dates to be inserted once they are finalized) ~~October 10 – November 10, 2017~~. Massachusetts outreached broadly to the public and to interested stakeholders to solicit input on the renewal applications for these waivers. The four waiver renewal applications were posted to MassHealth's website, and public notices were issued in multiple newspapers, including: the Boston Globe, Worcester Telegram and Gazette, and the Springfield Republican. In addition, emails were sent to several hundred recipients, which included key advocacy organizations as well as the Native American tribal contacts. The newspaper notices and email provided the link to the MassHealth website that includes the draft renewal applications, the public comment period, and, for anyone wishing to send comments, both email and mailing addresses. ~~The state received comments as oral testimony at the public forum as well as through email and mail from 5 individuals and organizations on the proposed renewal applications, including from a family member of a waiver participant.~~

~~Most of the comments addressed the proposed growth in slot capacity for the waivers over the five-year waiver period and the differences in services between the MFP waivers and the ABI waivers. Some commenters also had questions regarding the parameters of the new aggregate monthly service limit described in Attachment #1 and Appendix C-4. In response to comments received, the state made revisions to clarify provider qualifications for the new Community Based Day Supports service and to clarify the new service limit.~~

MassHealth outreached to and communicated with the Tribal governments about the ABI and MFP waiver renewal applications during regularly scheduled tribal consultation quarterly meetings on August 9, 2022~~17 and on November 8, 2017~~. The tribal consultation quarterly meetings afford direct discussions with Tribal government contacts about these waivers. ~~The tribal governments did not offered any comments or advice on the waiver renewal applications.~~

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date as provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	Bernstein				
First Name:	Amy				
Title:	Director of HCBS Waiver Administration				
Agency:	MassHealth				
Address :	One Ashburton Place				
Address 2:	5th Floor				
City:	Boston				
State:	Massachusetts				
Zip:	02108				
Phone:	617-573-1751	**Ext:**		☐	**TTY**
Fax:	617-573-1894				
E-mail:	Amy.Bernstein@mass.gov				

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	Cahill				
First Name:	Tim				
Title:	Assistant Commissioner for Operations				
Agency:	Department of Developmental Services				
Address:	1000 Washington St				
Address 2:					
City:	Boston				
State:	Massachusetts				
Zip :	02118				
Phone:	617-624-7749	**Ext:**		☐	**TTY**
Fax:	617-624-7578				
E-mail:	Timothy.Cahill@mass.gov				

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under §1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

_____

State Medicaid Director or Designee

Submission Date:	

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:	Cassel Kraft				
First Name:	Amanda				
Title:	Assistant Secretary and Director of MassHealth				
Agency:	Executive Office of Health and Human Services				
Address:	One Ashburton Place				
Address 2:	11th Floor				
City:	Boston				
State:	Massachusetts				
Zip:	02108				
Phone:	617-573-1600	**Ext:**		☐	**TTY**
Fax:	617-573-1894				
E-mail:	Amanda.Casselkraft@mass.gov				

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

~~The state is making two changes as noted above.~~

~~Eliminating services: Since its inception, the MFP-RS waiver has operated concurrently with a 1915(b) waiver. The state is not renewing the 1915(b) waiver, and will therefore eliminate certain MFP-RS waiver services that were components of the managed behavioral health benefit associated with the 1915(b) waiver. The goal of concurrently operating the 1915(b)(c) waivers was to enroll 1915(c) waiver participants into a managed behavioral health care plan in order to coordinate needed behavioral health services. Operationally, however, the state found that participants generally obtained behavioral health services through the MassHealth state plan and that the value added by the concurrent 1915(b)(c) waivers was found primarily in having a locus of support and navigation to coordinate provision of behavioral health services. The state is therefore adding a service to the 1915(c) waiver specifically to support participants in navigating/supporting access to behavioral health services, as described below and in Appendix C.~~

~~In its renewal of the 1915(c) MFP-RS waiver, the state will include the following service: Community Behavioral Health Support and Navigation. This service is defined in Appendix C, as are the types of providers and required qualifications. Essentially, this service will help to organize the needed state plan services for such participants and to support and guide their use and access to such behavioral health services. As described in the renewal application, the new service, Community Behavioral Health Support and Navigation (CBHSN) is not a clinical treatment service, but rather provides outreach and support to enable participants to utilize available clinical treatment services and other supports and works to mitigate barriers to doing so. This service replaces a similar service formerly available under the Community Psychiatric Support and Treatment capitation component that saw limited utilization.~~

~~In declining to renew the 1915(b), the state will no longer provide the following services through the 1915(c) waiver: Addiction Services; Community Crisis Stabilization; Community Psychiatric Support and Treatment; and Medication Administration. As noted, the predominant use of behavioral health services for these waiver participants was through the MassHealth state plan. As such, the inclusion of these services as a managed benefit overly complicated participants' access to services and ultimately proved inefficient and unnecessary. Through this change, the state seeks to streamline and make the availability and access to needed behavioral health services more direct and straightforward for participants in the MFP-RS waiver. No waiver participants will lose waiver eligibility due to the elimination of the four capitation components as services from the 1915(c) waivers, and no waiver participants are at risk of institutionalization due to this change.~~

~~Adding service limits: The state is adding the following waiver service: Community Based Day Supports (CBDS). The addition of CBDS to this waiver will increase participants' options for and access to flexible, individualized and meaningful day activities in keeping with the intent of the Community Rule. In order to appropriately plan for provision of this service in the participants' care plans, a limit is necessary in that this service would be duplicative of an existing (and continuing) waiver service: Day Services. The new CBDS service will be billed on a quarter hour basis, while Day Services is billed on a per diem. Therefore, on any day an individual receives Day Services, it would be duplicative to also receive CBDS. The limit being added is that Day Services may not be provided to a participant on the same day as CBDS, pre-vocational services, or supported employment. Further, an aggregate limit of 156 hours per month will apply for the following set of services: Day Services, CBDS, pre-vocational services, and supported employment services. CBDS, pre-vocational services, and supported employment may be used in combination on the same day. CBDS, Pre-vocational services, supported employment services, and Day Services may be used in combination as specified in a participant's Plan of Care up to the aggregate limit of 156 hours per month; however, Day Services may not be used in~~

~~combination with these other services on any given day. The state intends the new preclusion as a safeguard to prevent duplicative provision of site-based Day Services and non-sited day services, primarily CBDS, on a given day. Feedback from the stakeholder community, described above, indicated that waiver participants generally do not participate in more than six hours of Day Services or other community-based day services on a given day.~~

~~MassHealth, DDS, and MRC have reviewed utilization data to identify all participants currently using Day Services as well as supported employment services. DDS Service Coordinators will support participants whose service utilization will be affected by the new limits described above through the person-centered planning process to ensure the participants' needs are met.~~

~~One other change is addressed in this renewal application: a change to the name of the waiver. This waiver has been known as the Money Follows the Person-Residential Supports waiver, referred to as the MFP-RS waiver. Because the Money Follows the Person Demonstration is winding down, it is timely to change this name. The new name of this waiver will be the Moving Forward Plan-Residential Supports waiver. It will therefore continue to be referred to as the MFP-RS waiver. Massachusetts does not anticipate that the proposed name change will have any impact on or cause any confusion for participants or stakeholders. It is anticipated that by keeping the MFP acronym, but assigning the waivers a name that is distinct from the Money Follows the Person Demonstration Grant, participants and other stakeholders will be assured that the 1915(c) waivers are continuing after the Demonstration has ended.~~

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Massachusetts Executive Office of Health and Human Services (EOHHS), the single State Medicaid Agency (MassHealth) convened an interagency workgroup to address how best to comply with the requirements of the federal Home and Community Based settings at 42 CFR 441.301 (c)(4)-(5). The Department of Developmental Services (DDS), an agency within EOHHS that has primary responsibility for day-to-day operation of the MFP-RS waiver, participated in the workgroup. All regulations, policies, standards, certifications and procedures have been reviewed against the Community Rule HCBS Regulations and necessary changes identified. These include:

- Revisions to DDS regulations 115 CMR 7.00 (complete)
- Revisions to DDS regulations 115 CMR 8.00 (Chapter 8.00 articulates the system DDS uses to license and certify its providers. Revisions to this certification process are complete and were implemented on September 1, 2016.)~~initial changes made in July 2016; additional revisions under review for future promulgation)~~
- Issue guidance on requirement for locks on bedroom doors (complete)
- Incorporation of requirements for locks on bedroom doors into Licensure and Certification tool (complete)
- Incorporation of requirements for residency agreements into Licensure and Certification tool (complete)
- Develop and implement policy manual (~~in process; full implementation anticipated January 2017~~ (complete)
- Develop and distribute the waiver participant handbook (complete)

DDS conducted a review of existing residential settings in the MFP-RS and ABI-RH waivers to determine those settings that had a license and certification in good standing. For Assisted Living sites, where licensure is not applicable, the review determined whether they were credentialed in good standing. This review included development of a review tool that borrowed extensively from the CMS exploratory questions and review of settings by DDS Central Office, Regional and Area Office staff to categorize settings as compliant, requiring minor changes to comply, requiring more extensive changes to comply, or unable to comply. Based upon the DDS review and assessment, all the 24 hour residential settings serving participants in the MFP-RS and the ABI-RH waivers were determined to be in compliance with federal HCB settings requirements with the exception of consistently having locks on all individual participant's bedroom doors and legally enforceable leases. The state is taking a system-wide approach to transitioning residential settings to compliance in these areas by issuing guidance and incorporating the requirements for locks on bedroom doors and for residency agreements into the Licensure and Certification tool, as noted above. Compliance will be monitored on a site-specific basis through the licensing and certification process.

~~DDS developed and distributed a survey to providers of day services in collaboration with the Massachusetts Rehabilitation Commission (MRC). DDS staff reviewed survey results along with site-specific program data for providers that contract with both DDS and MRC. Based on this review, it was determined that all of the day services providers that contract with both DDS and MRC require some level of modification to come into full compliance with the Community Rule. The state is taking a system-wide approach to transitioning day service settings to compliance by developing clear programmatic standards and incorporating changes in the Licensure and Certification tool to facilitate stronger monitoring of CBDS settings. These activities are in process, with completion anticipated March 2019. Compliance will be monitored on a site-specific basis through the licensing and certification process.~~

~~The assessment process for group supported employment settings occurred against the backdrop of the state's existing Blueprint for Success, including Next Steps and Progress Reports associated with that document. DDS reviewed site-specific data across a range of group employment settings and determined that state-wide, all group employment settings that are licensed or certified by DDS require some level of modification to achieve full compliance with the Community Rule, particularly regarding policies or practices in one or more of the following domains: meaningful integration into the workplace; access to workplace amenities to the same degree as non-disabled workers; and assurance that individuals are earning at least the minimum wage. The state is taking a system-wide approach to transitioning group employment settings to compliance by developing clear definitions, standards, and criteria for integration for group employment. These activities are in process, with completion anticipated March 2019. At the site-specific level, compliance will be monitored through the licensing and certification process.~~

Most providers of Day and Employment services that serve MFP-RS waiver participants are licensed or certified by DDS. These providers are the subject of an open bid process and are required to be qualified to provide services and supports. This process demonstrates DDS's commitment to the HCBS settings requirements.

Following qualification, providers of Day and Employment services are subject to licensure and certification on an on-going basis. Certification outcomes also focus on rights, choice, control, employment and meaningful day activities, and community integration. As part of ongoing monitoring to ensure that providers are moving to enhance their outcomes, DDS revised its licensure and certification tool to clarify expectations and even more closely and strongly align the tool with the critical elements of the Community Rule.

In addition, for ABI and MFP day and employment providers not qualified through the above process by DDS, the Massachusetts Rehabilitation Commission Provider Standards for Acquired Brain Injury (ABI) and Moving Forward Plan (MFP) Waiver Service Providers identify the requirements to become credentialed to provide waiver day and employment services.

Through these processes, all day and employment providers have been determined to be in full compliance with the Community Rule.

All waiver providers will be subject to ongoing review on the schedule outlined in Appendix C of the waiver application.

Individuals receiving services in settings that cannot meet requirements will be notified by the state agency providing case management. The case manager will review with the participant the services available and the list of qualified and fully compliant providers, and will assist the participant in choosing the services and providers, from such list, that best meet the participant's needs and goals.

For all settings in which changes will be required, DDS has instituted an on-going compliance review process to assure that the changes are monitored and occur timely and appropriately. This process will include consultation and support to providers to enable them to successfully transition, quarterly reporting by providers to update DDS on progress towards compliance, and reviews by designated Area, Regional and Central Office DDS staff to assure adherence to transition plans and processes.

All settings in which waiver services are delivered will be fully compliant with the HCBS Community Rule no later than March, 20233~~2~~.

The State is committed to transparency during the waiver renewal process as well as in all its activities related to Community Rule compliance planning and implementation in order to fully comply with the HCBS settings requirements by or before March 20233~~2~~. If, in the course of monitoring activities, DDS determines that additional substantive changes are necessary for certain providers or settings, MassHealth and DDS will engage in activities to ensure full compliance by the required dates, and in conformance with CMS requirements for public input.

The state assures that the settings transition plan included with this waiver renewal will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. The State will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Orientation and Mobility services:

Rates for Orientation and Mobility services were based on the historic rate for such services from the rate regulation 101 CMR 356.00: Rates for Money Follows the Person Demonstration Services. These rates were built off the 2012 Medicare rate for CPT code 97535, adjusted for the average of the two Massachusetts Geographical Price Cost Indices and multiplied by 85% to reflect that providers are mid-level (non-physician) practitioners. The rates remained unchanged based on provider input gathered during the public hearing process for the proposed rate updates to the rates established under 101 CMR 359.00.

CMS Response #2: Provide the Medicare CPT 97535 rate source used to calculate the Orientation and Mobility services. We cannot determine the base data that the State used by using the CPT code and Year alone. We used the below web address to locate the Medicare physician services rate.

https://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx

However, this website requires more detail than what the State provided. The search criteria included year, type of information, MAC option, and modifier. For example, year 2012 has two options to choose from – 2012A and 2012B. Provide the specific search criteria the State selected to derive the CPT 97535 rate.

MA Response #3:

The criteria for the website are as follows:

Type of Info=All MAC option= Specific Locality, for both 1420201 Metropolitan Boston and 1420299 Rest of Massachusetts

Modifier=All modifiers

There is no difference in the 2012A and 2012B rates for this CPT code.

In reviewing the documentation for this rate, however, the state identified a clerical error in the original calculations from 2013.

The base utilized to calculate this rate was set at $36.49 rather than the average rate of $35.36 shown below:

Medicare 2012 A

-Metro Boston: $36.14

-Rest of MA: $34.58

-Average: $35.36

Medicare 2012 B

-Metro Boston: $36.14

-Rest of MA: $34.58

-Average: $35.36

Listed rate in the analysis documents as the base rate: $36.49:

Prevocational and Supported Employment Services:

Rates for Prevocational and Supported Employment Services are based on historic rates for such services from the rate regulation 114.4 CMR 10.00: Rates for Competitive Integrated Employment Services. The rates were then updated with a retrospective CAF of 6.86%.

CMS Response #2:

Provide additional information about the retroactive CAF adjustment. How is 6.86% calculated?

MA Response #3: Data for the calculation of the CAF came from Global Insights. The CAF is the percent increase between the base period index number and the effective period index number. The percent increase is found by subtracting the effective period number minus the base period number. That difference is then divided by the base period number to find the percent increase. The base period number is the listed index value for 2012Q3 (2.533). The effective period number is the average of the index numbers over the effective period of the rate regulation (2017Q1 through 2018Q4), as follows:

2017Q1: 2.659
2017Q2: 2.671
2017Q3: 2.687
2017Q4: 2.696
2018Q1: 2.712
2018Q2: 2.727
2018Q3: 2.743
2018Q4: 2.759
Average: 2.707

Retroactive CAF = (2.707 – 2.533) ÷ 2.533 = 6.86%

As noted previously, all rates established in regulation by EOHHS are required by statute to be reviewed biennially and updated as applicable, to ensure that they continue to meet statutory rate adequacy requirements. In updating rates to ensure continued compliance with statutory rate adequacy requirements, a cost adjustment factor (CAF) or other updates to the rate models may be applied. No productivity expectations and administrative ceiling calculations have been used in establishing these rates.

CMS Response #2:

See above, additional information is requested regarding the State's CAF adjustment.

MA Response #3:

Data for the calculation of the CAF came from Global Insights. The CAF is the percent increase between the base period index number and the effective period index number. The percent increase is found by subtracting the effective period number minus the base period number. That difference is then divided by the base period number to find the percent increase. The base period number is the listed index value for 2012Q3 (2.533). The effective period number is the average of the index numbers over the effective period of the rate regulation (2017Q1 through 2018Q4), as follows:

2017Q1: 2.659

2017Q2: 2.671
2017Q3: 2.687
2017Q4: 2.696
2018Q1: 2.712
2018Q2: 2.727
2018Q3: 2.743
2018Q4: 2.759
Average: 2.707

Retroactive CAF = (2.707 – 2.533) ÷ 2.533 = 6.86%

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver *(select one)*:

☑	The waiver is operated by the state Medicaid agency. Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one)*:		
	○	The Medical Assistance Unit *(specify the unit name) (Do not complete Item A-2*)	
	☑	Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit. Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency. (*Complete item A-2-a)*	The Department of Developmental Services. While DDS is organized under EOHHS and subject to its oversight authority, it is a separate agency established by and subject to its own enabling legislation.
○	The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency. Specify the division/unit name:		
	In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (*Complete item A-2-b).*		

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities.

a) The Executive Office of Health and Human Services (EOHHS) contracts with a Level of Care entity which is responsible for determinations of clinical eligibility for the waiver and level of care redetermination.

The Massachusetts Rehabilitation Commission (MRC) and the Department of Developmental Services (DDS), in collaboration with MassHealth, oversee and assess the Level of Care entity on a continuous and ongoing basis through activities including but not limited to monitoring weekly, monthly and quarterly reporting by the LOC entity; participation in the LOC entity's weekly clinical eligibility process; reviewing all clinical denials; and monitoring appeals of clinical denials.

EOHHS also contracts with an Administrative Service Organization (ASO) which is responsible for managing the expansion and oversight of the waiver service provider network of MassHealth providers. MRC, with the collaboration of DDS, will ensure that contracting providers adhere to the contractual obligations imposed on them for performing these functions, will work with the contractors to provide any necessary training, regarding their performance of waiver functions and will collect and report information on waiver enrollees' utilization and experience with waiver enrollment.

~~As indicated in Appendix A-1 this waiver is operated by the Department of Developmental Services (DDS), a state agency within the single state agency, the Executive Office of Health and Human Services (EOHHS). Consistent with the concurrently operating MFP Community Living Waiver (MA.1027) the Massachusetts Rehabilitation Commission (MRC), another state agency within EOHHS has primary responsibility for oversight of the contracted Level of Care entity and Administrative Service Organization. MRC and DDS will collaborate in the oversight of these contracts as they relate to this waiver.~~

~~This oversight will include ensuring that the Level of Care entity adheres to the contractual obligations imposed on them for performing clinical eligibility, provide any necessary training, and collect and report information on waiver enrollment.~~

~~MRC and DDS, in collaboration with MassHealth, oversee and assess the Level of Care entity on a continuous and ongoing basis through activities including but not limited to monitoring weekly, monthly, and quarterly reporting by the LOC entity; onsite participation in the LOC entity's weekly clinical eligibility process; reviewing all clinical denials; and monitoring appeals of clinical denials.~~

~~MRC, with the collaboration of DDS, will work with the contractors to provide any necessary training, regarding their performance of waiver functions and will collect and report information on waiver enrollees' utilization and experience with waiver enrollment.~~

MRC, with the collaboration of DDS, will audit the Administrative Services Organization (ASO) annually. The audit includes review of all waiver functions this entity performs on behalf of MassHealth. Review of the ASO will include examination of the functions outlined in A-3, including recordkeeping, efficiencies and general performance.

In addition, the LOC and ASO submit reports for specific performance management indicators to both DDS and MassHealth on ~~at~~ an ~~least a semi-~~annual basis.

b) DDS and MRC have entered into Interagency Services Agreements with MassHealth to document the responsibility for performing and reporting on these functions.

~~c))MassHealth, within the Executive Office of Health and Human Services (EOHHS) the single state agency, will administer and oversee performance of the waiver. MassHealth also oversees MRC and DDS in their oversight of the contracted Level of Care and Administrative Service Organization contractors in the performance of their duties for this waiver. Once waiver operations have been established the frequency of oversight meetings will be re-evaluated. The Medicaid Director reviews and signs all waiver applications, amendments and waiver reports to CMS.~~

c) MassHealth, within the Executive Office of Health and Human Services (EOHHS) the single state agency, will administer and oversee performance of the waiver. MassHealth meets with MRC and DDS staff on a monthly basis regarding the performance of these activities and other operational aspects and reporting for these waivers. MassHealth also oversees MRC and DDS in

their oversight of the contracted Level of Care and Administrative Service Organization contractors in the performance of their duties for this waiver. The frequency of oversight meetings will be re-evaluated periodically. The Medicaid Director reviews and signs all waiver applications, amendments and waive reports to CMS.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (s*elect one)*:

☑	**Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).** Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*
	MassHealth contracts with a Level of Care entity to perform initial waiver eligibility assessments and annual redeterminations of clinical eligibility for the waiver. The Level of Care entity will verify MassHealth eligibility for participants. The Registered Nurses who are responsible for performing level of care re-evaluations will be staff of the Level of Care entity as previously described. MassHealth contracts with an Administrative Service Organization (ASO). The ASO solicits direct service providers, assists these providers in executing MassHealth provider agreements, verifies vendor qualifications and conducts vendor and quality monitoring activities. The ASO assumes or subcontracts billing agent responsibilities, and conducts customer service activities for both direct service providers and waiver participants. The ASO engages in multiple third party administrator activities including the following: - Recruiting and facilitating enrollment of waiver service providers in MassHealth so that waiver services and service locations are available and accessible to waiver participants. - Establishing and using MassHealth-approved enrollment criteria for ensuring that waiver service providers are qualified to provide the appropriate waiver services. - Assisting waiver service providers, as needed, with various aspects of waiver service claims processing and other related transactions. - Identifying quality issues and concerns for MassHealth and DDS. - Undertaking training activities as appropriate for providers and their staff.

	MassHealth contracts with Fiscal Management Service (FMS) entities that will be responsible for supporting the participant as the employer of self-directed services as outlined in Appendix E. The State will manage the performance of the FMS via contract, including review of performance metrics and required monthly reports. The agreements that outline the requirements for these contractors will be available to CMS upon request.
○	**No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity *(Select one)*:

☑	**Not applicable**
○	**Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:
	☐ **Local/Regional non-state public agencies** conduct waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these agencies and complete items A-5 and A-6:*
	☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these entities and complete items A-5 and A-6*:

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The Massachusetts Rehabilitation Commission (MRC), with the collaboration of the Department of Developmental Services (DDS) will oversee and assess the performance of the administrative services organization that will monitor the performance of waiver service providers. DDS will report to MassHealth on an~~t least a semi-~~annual basis regarding these activities and any issues or concerns regarding same.

6. Assessment Methods and Frequency. Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

MRC and DDS, in collaboration with MassHealth, oversee and assess the Level of Care entity on a continuous and ongoing basis through activities including but not limited to monitoring weekly, monthly, and quarterly reporting by the LOC entity; ~~onsite~~ participation in the LOC entity's weekly clinical eligibility process; reviewing all clinical denials; and monitoring appeals of clinical denials.

The MRC, with the collaboration of DDS, will audit the Administrative Services Organization (ASO) annually. The audit includes review of all waiver functions this entity performs on behalf of MassHealth. Review of the ASO will include examination of the functions outlined in A-3, including recordkeeping, efficiencies and general performance.

In addition, the ASO and the Level of Care entity will submit reports of identified performance and management indicators to DDS/MassHealth on at least an ~~semi-~~annual basis. MRC, with the collaboration of DDS, will be responsible for the annual submission of specific indicators and summary findings for waiver service and administrative oversight to MassHealth.

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	☑	☐	☐	☐
Waiver enrollment managed against approved limits	☑	☐	☐	☐
Waiver expenditures managed against approved levels	☑	☐	☐	☐
Level of care evaluation	☑	☐	☑	☐
Review of Participant service plans	☑	☐	☐	☐
Prior authorization of waiver services	☑	☐	☐	☐
Utilization management	☑	☐	☐	☐
Qualified provider enrollment	☑	☐	☑	☐
Execution of Medicaid provider agreements	☑	☐	☐	☐
Establishment of a statewide rate methodology	☑	☐	☐	☐
Rules, policies, procedures and information development governing the waiver program	☑	☐	☐	☐
Quality assurance and quality improvement activities	☑	☐	☑	☐

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities..

i Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:

- ***Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver***
- ***Equitable distribution of waiver openings in all geographic areas covered by the waiver***
- ***Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014).***

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	Participants are supported by competent and qualified case managers. (Number of Case Managers with a rating of "meets expectations" or "exceeds expectations" on their performance evaluations/ Number of Case Managers due for performance evaluation)		
Data Source *(Select one) (Several options are listed in the on-line application):*			
If 'Other' is selected, specify: **Performance Evaluations**			
	Responsible Party for data collection/generation	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*

	(check each that applies)		
	☑ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☑ *Annually*	
	Administrative Services Organization	☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☑ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	% of annual redeterminations with a completed Waiver LOC determination instrument before the end of 365 days. (Number of annual redeterminations with a completed Waiver LOC determination instrument before the end of 365 days/ Total number of individuals needing annual redeterminations)
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify: **Level of Care Entity reports**	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☑ *Other Specify:*	☑ *Annually*	
	Level of Care Entity	☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☑ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	MassHealth, MRC, DDS and the Fiscal Management Service agencies (FMS) work collaboratively to ensure systematic and continuous data collection and analysis of the FMS entity functions and systems, as evidenced by the timely and appropriate submission of required data reports. (The number of FMS reports submitted on time and in the correct format/Number of FMS reports due)
Data Source *(Select one) (Several options are listed in the on-line application):* **Reports to State Medicaid Agency on delegated Administrative functions**	

If 'Other' is selected, specify:

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☑ *Other Specify:*	☑ *Annually*	
	Fiscal Management Service agencies	☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☑ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	The ASO reviews waiver service providers in accordance with the requirements and schedule outlined in the contract with the Medicaid Agency. (Number of service provider reviews conducted by ASO/Number of service providers due for review)
Data Source *(Select one) (Several options are listed in the on-line application):* **Reports to State Medicaid Agency on delegated Administrative functions**	

If 'Other' is selected, specify:

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☑ *Other Specify:*	☑ *Annually*	
	Administrative Service Organization	☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☑ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

ii *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

The Department of Developmental Services (DDS) and MassHealth are responsible for ensuring effective oversight of the waiver program, including administrative and operational functions performed by the Level of Care entity and the Administrative Service Organization. As problems are discovered with the management of the waiver program, the Administrative Services Organization, or waiver service providers, MassHealth/DDS will ensure that a corrective action plan is created, approved, and implemented within appropriate timelines. Timelines for remediation will be dependent on the nature and severity of the issue to be addressed. Further, MassHealth is responsible for identifying and analyzing trends related to the operation of the waiver and determining strategies to address quality- related issues.

ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	***Responsible Party*** *(check each that applies)*	***Frequency of data aggregation and analysis:*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*
	☐ *Operating Agency*	☐ *Monthly*
	☐ *Sub-State Entity*	☐ *Quarterly*
	☐ *Other Specify:*	☑ *Annually*
		☐ *Continuously and Ongoing*
		☐ *Other Specify:*

c. Timelines

When the state does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

☑	**No**

○	**Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

Appendix B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to a group or subgroups of individuals. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Select One Waiver Target Group	Target Group/Subgroup		Minimum Age	Maximum Age	
				Maximum Age Limit: Through age –	No Maximum Age Limit
☑	**Aged or Disabled, or Both - General**				
	☑	Aged (age 65 and older)	65		☑
	☑	Disabled (Physical)	18	64	
	☐	Disabled (Other)			
☐	**Aged or Disabled, or Both - Specific Recognized Subgroups**				
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☐	**Intellectual Disability or Developmental Disability, or Both**				
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Mental Retardation			☐
☑	**Mental Illness** *(check each that applies)*				
	☑	Mental Illness	18	64	☐
	☐	Serious Emotional Disturbance			

b. Additional Criteria. The state further specifies its target group(s) as follows:

The target group for this waiver includes adults, age 18 and over, with physical disabilities or mental illness, or both. Applicants to the MFP Residential Habilitation (MFP-RS) Waiver must also meet the following program criteria to participate in the waiver:
1. Reside (and have resided for a period of not less than 90 consecutive days) in an inpatient facility (specifically a nursing facility, chronic disease or rehabilitation hospital, or psychiatric hospital);
2. Meet the level of care criteria as specified in Appendix B.6.d.;
3. Be able to be safely served in the community within the terms of the MFP-RS Waiver and services provided therein;
4. The applicant must need a residential support service within the terms of the MFP-RS Waiver.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one)*:

○	Not applicable. There is no maximum age limit
☑	The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit. *Specify*:
	Not applicable. There is no maximum age limit.

Appendix B-2: Individual Cost Limit

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

☑ **No Cost Limit**. The state does not apply an individual cost limit. *Do not complete Item B-2-b or Item B-2-c*.

○ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c*. The limit specified by the state is *(select one)*:

- ○ **%** — A level higher than 100% of the institutional average. Specify the percentage:
- ○ Other *(specify)*:

○ **Institutional Cost Limit**. Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c*.

○ **Cost Limit Lower Than Institutional Costs**. The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver. *Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c*.

The cost limit specified by the state is *(select one)*:

○ **The following dollar amount**: Specify dollar amount:

The dollar amount *(select one)*:

○ **Is adjusted each year that the waiver is in effect by applying the following formula:** Specify the formula:

○ **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**

	○	**The following percentage that is less than 100% of the institutional average:**		
	○	**Other:** *Specify:*		

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

☐	**The participant is referred to another waiver that can accommodate the individual's needs.**
☐	**Additional services in excess of the individual cost limit may be authorized.** Specify the procedures for authorizing additional services, including the amount that may be authorized:
☐	**Other safeguard(s)** *(Specify)*:

Appendix B-3: Number of Individuals Served

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a	
Waiver Year	**Unduplicated Number of Participants**
Year 1	~~364~~624
Year 2	~~424~~674
Year 3	~~484~~724
Year 4 (only appears if applicable based on Item 1-C)	~~529~~774
Year 5 (only appears if applicable based on Item 1-C)	~~574~~824

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)*:

☑	**The state does not limit the number of participants that it serves at any point in time during a waiver year.**
○	**The state limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table B-3-b	
Waiver Year	**Maximum Number of Participants Served At Any Point During the Year**
Year 1	
Year 2	
Year 3	
Year 4 (only appears if applicable based on Item 1-C)	
Year 5 (only appears if applicable based on Item 1-C)	

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

○	**Not applicable**. **The state does not reserve capacity.**		
☑	**The state reserves capacity for the following purpose(s).** Purpose(s) the state reserves capacity for: Waiver Transfer		
	Table B-3-c		
		Purpose (provide a title or short description to use for lookup):	**Purpose** (provide a title or short description to use for lookup):
		Waiver Transfer	
		Purpose (describe):	**Purpose** (describe):
		The state reserves capacity for individuals who have been receiving service from another 1915(c) waiver or receiving State Plan services who now require the services of the MFP-RS waiver to meet their needs. MFP-CL, ABI-RH, and ABI-N Waiver Participants, and MFP Demonstration Participants within their MFP Demonstration period or up to 180 days thereafter, who request a transfer to the MFP-RS Waiver will be considered to have met the additional targeting criteria outlined in Appendix B-1-b item #1. All such individual must meet the remaining eligibility criteria as outlined in Appendix B-1-b.	
		Describe how the amount of reserved capacity was determined:	**Describe how the amount of reserved capacity was determined:**
		The reserved capacity is an estimate of anticipated need for waiver transfers and will be adjusted if necessary based on actual experience.	
	Waiver Year	**Capacity Reserved**	**Capacity Reserved**

	Year 1	3	
	Year 2	3	
	Year 3	3	
	Year 4 (only if applicable based on Item 1-C)	3	
	Year 5 (only if applicable based on Item 1-C)	3	

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one):*

☑	**The waiver is not subject to a phase-in or a phase-out schedule.**
○	**The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an *intra-year* limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

☑	**Waiver capacity is allocated/managed on a statewide basis.**
○	**Waiver capacity is allocated to local/regional non-state entities. Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:**

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

I. Residents of Inpatient Facilities

1. Applicants to the MFP-RS waiver shall meet all requirements for eligibility in Massachusetts' Medicaid program, including without limitation, all regulations establishing medical assistance eligibility requirements related to the filing of applications for assistance, verifications, re-determinations, existence of a disabling condition, citizenship status, residency, institutional status, assistance unit composition and income and asset limits.

2. There is a limit on the number of participants in the waiver. Waiver entrance is managed against the approved limit. Applicants will be assessed on a first come first served basis based on the date of their application for the waiver. Entrance to the waiver is offered to individuals based on the date of their eligibility determination, with the ability to accommodate applicants meeting the criteria for the reserved capacity category.

3. Any applicants who are denied entry to the waiver will be offered the opportunity to request a fair hearing as noted in Appendix F.

II. Moving Forward Plan Community Living (MFP-CL) and Acquired Brain Injury with Residential Habilitation (ABI-RH), and Acquired Brain Injury Nonresidential Habilitation (ABI-N) Waiver participants and MFP Demonstration participants

1. The following individuals may request a transfer to the MFP-RS waiver: MFP-CL, ABI-N, and ABI-RH Waiver Participants. These applicants will be considered to have met the requirement of having resided for a period of not less than 90 consecutive days in an inpatient facility. MFP Demonstration participants within their MFP Demonstration period and MFP Demonstration participants within 180 days of the conclusion of the MFP Demonstration period may request a transfer to the MFP-RS waiver only if they resided for a period of not less than 90 consecutive days in an inpatient facility (specifically, a nursing facility, chronic disease or rehabilitation hospital, or psychiatric hospital) prior to their enrollment in the MFP Demonstration. Such Participants who request enrollment in the MFP-RS Waiver will be subject to all other requirements for enrollment in the MFP-RS waiver. These applicants will be accepted based on availability of open capacity in the waiver on the date of their determination of eligibility.
~~The following individuals may request a transfer to the MFP-RS waiver: MFP-CL, ABI-RH, and ABI-N Waiver Participants; MFP Demonstration participants within their MFP Demonstration period, and MFP Demonstration participants within 180 days of the conclusion of the MFP Demonstration period. These applicants will be considered to have met the requirement of having resided for a period of not less than 90 consecutive days in an inpatient facility. Such Participants who request enrollment in the MFP-RS Waiver will be subject to all other requirements for enrollment in the MFP-RS waiver. These applicants will be accepted based on availability of open capacity in the waiver on the date of their determination of eligibility.~~

2. Any applicants who are denied entry to the waiver will be offered the opportunity to request a fair hearing as noted in Appendix F.

Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

a. 1. State Classification. The state is a *(select one)*:

☑	§1634 State
○	SSI Criteria State
○	209(b) State

2. Miller Trust State.

Indicate whether the state is a Miller Trust State *(select one)***.**

☑	No
○	Yes

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)			
☐	Low income families with children as provided in §1931 of the Act		
☑	SSI recipients		
☐	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121		
☑	Optional state supplement recipients		
☑	Optional categorically needy aged and/or disabled individuals who have income at: *(select one)*		
	☑	100% of the Federal poverty level (FPL)	
	○	%	of FPL, which is lower than 100% of FPL Specify percentage:
☐	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)		
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)		
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)		
☐	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)		
☐	Medically needy in 209(b) States (42 CFR §435.330)		
☐	Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)		
☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver) *specify*:		

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

○	**No**. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.
☑	**Yes**. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. *Select one and complete Appendix B-5.*

○	All individuals in the special home and community-based waiver group under 42 CFR §435.217
☑	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 *(check each that applies)*:

☑	A special income level equal to (select one):

☑		300% of the SSI Federal Benefit Rate (FBR)
○	%	A percentage of FBR, which is lower than 300% (42 CFR §435.236) Specify percentage:
○	$	A dollar amount which is lower than 300% Specify percentage:

☐	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
☐	Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
☐	Medically needy without spend down in 209(b) States (42 CFR §435.330)
☐	Aged and disabled individuals who have income at: *(select one)*

○		100% of FPL
○	%	of FPL, which is lower than 100%

☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver) *specify*:

Appendix B-5: Post-Eligibility Treatment of Income

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217.

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☑	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act. *Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.*

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).

☑		Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state elects to (*select one*):
	☑	Use *spousal* post-eligibility rules under §1924 of the Act. *Complete ItemsB-5-b-2 (SSI State and §1634) or B-5-c-2 (209b State) and Item B-5-d.*
	○	Use *regular* post-eligibility rules under 42 CFR §435.726 (SSI State and §1634) (*Complete Item B-5-b-1*) or under §435.735 (209b State) (*Complete Item B-5-c-1). Do not complete Item B-5-d.*
○		Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse. *Complete Item B-5-c-1 (SSI State and §1634) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.*

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules. However, for the five-year period beginning on January 1, 2014, post-eligibility treatment-of-income rules may not be determined in accordance with B-5-b-1 and B-5-c-1, because use of spousal eligibility and post-eligibility rules are mandatory during this time period.

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b-2. Regular Post-Eligibility Treatment of Income: SSI State. The state uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
☑	The following standard included under the state plan *(Select one):*			
	○	**SSI standard**		
	○	**Optional state supplement standard**		
	○	**Medically needy income standard**		
	☑	**The special income level for institutionalized persons** *(select one):*		
		☑	**300% of the SSI Federal Benefit Rate (FBR)**	
		○ %	**A percentage of the FBR, which is less than 300%** Specify the percentage:	
		○ $	**A dollar amount which is less than 300%.** Specify dollar amount:	
	○ %		A percentage of the Federal poverty level Specify percentage:	
	○	**Other standard included under the state Plan** Specify:		
○	**The following dollar amount** Specify dollar amount:	$	If this amount changes, this item will be revised.	
○	**The following formula is used to determine the needs allowance:** Specify:			
○	Other Specify:			

ii. <u>Allowance for the spouse only</u> (*select one*):			
☑	**Not Applicable**		
Specify the amount of the allowance (*select one*):			
○	**SSI standard**		
○	**Optional state supplement standard**		
○	**Medically needy income standard**		
○	**The following dollar amount:** Specify dollar amount:	$	If this amount changes, this item will be revised.

○	**The amount is determined using the following formula:** *Specify:*

iii. Allowance for the family *(select one)*:

☑	**Not Applicable *(see instructions)***
○	**AFDC need standard**
○	**Medically needy income standard**
○	**The following dollar amount:** $ Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*
○	**Other** *Specify:*

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

☑	**Not applicable *(see instructions)*** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
○	**The state does not establish reasonable limits.**
○	**The state establishes the following reasonable limits** *Specify*:

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

*(select one)***:**

○	**SSI Standard**		
○	**Optional state supplement standard**		
○	**Medically needy income standard**		
☑	**The special income level for institutionalized persons**		
○	%	Specify percentage:	
○	**The following dollar amount:**	$	If this amount changes, this item will be revised
○	**The following formula is used to determine the needs allowance:** *Specify formula:*		
○	**Other** *Specify***:**		

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

☑	**Allowance is the same**
○	**Allowance is different.** *Explanation of difference:*

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under state law but not covered under the State's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

☑	**Not applicable (see instructions)** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
○	**The state does not establish reasonable limits.**

○	**The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

NOTE: Items B-5-e, B-5-f and B-5-g only apply for the five-year period beginning January 1, 2014. If the waiver is effective during the five-year period beginning January 1, 2014, and if the state indicated in B-5-a that it uses spousal post-eligibility rules under §1924 of the Act before January 1, 2014 or after December 31, 2018, then Items B-5-e, B-5-f and/or B-5-g are not necessary. The state's entries in B-5-b-2, B-5-c-2, and B-5-d, respectively, will apply.

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: SSI State and §1634 State – 2014 through 2018. The state uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

☑ The following standard included under the state plan
(Select one):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ☑ **The special income level for institutionalized persons**
  (select one):
  - ☑ **300% of the SSI Federal Benefit Rate (FBR)**
  - ○ % **A percentage of the FBR, which is less than 300%**
    Specify the percentage:
  - ○ $ **A dollar amount which is less than 300%.**
    Specify dollar amount:
- ○ % **A percentage of the Federal poverty level**
  Specify percentage:
- ○ **Other standard included under the state Plan**
  Specify:

○ **The following dollar amount** Specify dollar amount: | $ | If this amount changes, this item will be revised.

○ **The following formula is used to determine the needs allowance:**
Specify:

○ **Other**
Specify:

ii. Allowance for the spouse only (*select one*):

☑ **Not Applicable**

○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**
Specify:

Specify the amount of the allowance (*select one*):

○ **SSI standard**

○	**Optional state supplement standard**		
○	**Medically needy income standard**		
○	**The following dollar amount:** Specify dollar amount:	$	If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*		

iii. <u>Allowance for the family</u> *(select one)*:

☑	**Not Applicable *(see instructions)***		
○	**AFDC need standard**		
○	**Medically needy income standard**		
○	**The following dollar amount:** Specify dollar amount:	$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*		
○	**Other** *Specify:*		

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

☑	**Not applicable *(see instructions)*** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
○	**The state does not establish reasonable limits.**
○	**The state establishes the following reasonable limits** *Specify*:

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules – 2014 through 2018

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

*(select one)***:**

○	**SSI Standard**		
○	**Optional state supplement standard**		
○	**Medically needy income standard**		
☑	**The special income level for institutionalized persons**		
○	%	Specify percentage:	
○	**The following dollar amount:**	$	If this amount changes, this item will be revised
○	**The following formula is used to determine the needs allowance:** *Specify formula:*		
○	**Other** *Specify***:**		

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

☑	**Allowance is the same**
○	**Allowance is different.** *Explanation of difference:*

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

☑	**Not applicable (see instructions)** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
○	**The state does not establish reasonable limits.**

○	**The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B-6: Evaluation / Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for waiver services:

i. Minimum number of services.
The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is*:*

1

ii. Frequency of services. The state requires (select one):

○ **The provision of waiver services at least monthly**

☑ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

Waiver services must be scheduled on at least a monthly basis. The participant's case manager will be responsible for monitoring on at least a monthly basis when the individual doesn't receive scheduled services for longer than one month (for example when absent from the home due to hospitalization). Monitoring may include ~~face-to-face or~~in-person, telephone, video-conferencing and/or other electronic modalities ~~contact~~ with the participant and may also include collateral contact with formal or informal supports. These contacts will be documented in the participant's case record.

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

○ **Directly by the Medicaid agency**

○ **By the operating agency specified in Appendix A**

☑ **By a government agency under contract with the Medicaid agency.**
Specify the entity:

Registered nurses from the level of care entity are responsible for making initial level of care decisions and performing level of care reevaluations.

○ **Other**
Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

The registered nurse performing waiver evaluations must:

Possess a valid license issued by the Massachusetts Board of Registration of Nursing and be in good standing;

Have knowledge and applicable experience working with frail elders, individuals with disabilities and their families;

Have knowledge of Medicaid, state agencies and the provider service system and community based resources available to serve persons with disabilities or elders; and

Have a minimum of two years of experience with home care, discharge planning, service planning and performing clinical eligibility determinations.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

A person will be considered to meet a nursing facility level of care if the individual meets the criteria as defined in 130 CMR 456.409 (MassHealth Nursing Facility Regulation that describe the requirements for medical eligibility for nursing facility services). The MassHealth nursing facility provider regulations define in 130 CMR 456.409 the nursing facility level of care criteria. To be considered medically eligible for nursing facility services, you must require one skilled service daily or require a combination of at least three services that support activities of daily living and nursing services, one such service of which must be a nursing service.

Alternatively, a person will be considered to meet a chronic/rehabilitation hospital or a psychiatric hospital level of care if the individual has a medical, cognitive, or psychiatric condition that results in cognitive, behavioral and/or functional deficits that require assistance or support, for at least three needs, from within the categories described below, at least one of which must be from category II (Behavior Intervention) or category III (Cognitive Abilities). Regardless of whether an individual exhibits one or more impairments in category IV (Functional and Independent Living Skill Development) this category may count as a maximum of one deficit for purposes of determining eligibility.

I. Assistance with Activities of Daily Living (ADL) and Nursing Needs
A. ADL assistance includes continual supervision required throughout the task or activity, or daily limited, extensive, maximal physical assistance, or total dependence per MDS-HC, for needs with the following activities
1. Bathing - complete body bath via tub, shower or bathing system
2. Dressing - dressed in street clothes including underwear
3. Toileting - assistance to & from toilet, includes catheter, urostomy or colostomy care
4. Transfers - assistance to & from bed, chair or wheelchair
5. Locomotion Inside and Outside Home - movement inside and outside the home, excluding stairs. Note if the participant uses a wheelchair, self-sufficiency once in wheelchair

6. Eating - does not include meal or tray preparation
7. Bed Mobility-requires physical assistance of at least one person to change positions while in bed.

B. Nursing Services. Nursing services, including any of the following procedures performed at least three times a week, may be counted in the determination of eligibility:
1. Any physician-ordered skilled service specified in 130 CMR 456.409(A) (MassHealth Nursing Facility Regulation that describes the skilled service requirement for nursing facility eligibility);
2. Positioning while in bed or a chair as part of the written care plan;
3. Administration of oral or injectable medications that require a registered nurse to monitor the dosage, frequency, or adverse reactions;
4. Physician-ordered occupational, physical, speech/language therapy or some combination of the three;
5. Physician-ordered licensed registered nursing observation and/or vital-signs monitoring, specifically related to the need for medical or nursing intervention; and
6. Treatments involving prescription medications for uninfected postoperative or chronic conditions according to physician orders, or routine changing of dressings that require nursing care and monitoring.

II. Behavior Intervention: Staff intervention required for selected types of behaviors that are generally considered to present excessive risk of harm to self or others, or considered dependent or disruptive, such as disrobing, screaming, or being physically abusive to oneself or others; getting lost or wandering into inappropriate places; being unable to avoid simple dangers. Risk indicators and behaviors include:
1. Wandering or getting lost
2. Verbally abusive
3. Physically abusive (physically assaultive/exhibition of violence toward others)
4. Socially inappropriate/disruptive behavior that requires ongoing and consistent staff intervention, including problematic sexual behaviors (impulsivity, public masturbation, inappropriate sexual advances)
5. Inability to avoid simple dangers, to react appropriately to unsafe situations (ability to exit building in response to fire/natural disaster) and/or to curtail activities that create dangers to self or others such as fire safety issues, including unsafe smoking practices, unsafe cooking, fire setting behaviors
6. Substance abuse
7. History of non-adherence to treatment and/or medication regimens
8. Suicidal ideation or attempts

III. Cognitive Abilities:
1. Communication which includes Receptive language (comprehension) in the individual's native language - Ability to understand through any means such as verbal, written, sign language, Braille, computer technology or communication board;
2. Expressive language in the individual's native language - Ability to express needs through any means such as verbal, written, sign language, Braille, computer technology or communication board;
3. Memory and Learning - Ability to learn, understand, retain or retrieve information for purposes of habilitating day to day and generally managing within one's environment;
4. Orientation - Requiring ongoing and consistent staff intervention for reality orientation related to a specific diagnosis as diagnosed by a licensed clinician.

IV. Functional and Independent Living Skill Development
1. Meal preparation,
2. Ordinary Housework (includes laundry)
3. Budgeting and Personal Finances
4. Managing Medications

5. Outdoor Mobility
6. Transportation
7. Grocery Shopping
8. Personal Hygiene

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

○	**The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**
☑	**A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.** Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

The MDS-HC, plus several additional assessment questions, are used for re-evaluation of level of care for the waiver. The additional questions are used to document the skilled nursing needs and their frequency, staff monitoring, oversight or intervention required for behavior intervention and staff intervention needed for memory and learning and reality orientation.

The MDS-HC is the same tool used by MassHealth's agents to evaluate level of care of nursing facility residents to determine eligibility for payment. ~~Chronic and rehabilitation hospitals assess for level of care utilizing the Medicare Adult Appropriateness Evaluation Protocol (AEP) utilized by the Peer Review Organization.~~ MassHealth Office of Clinical Affairs nurse reviewers assess chronic and rehabilitation hospital patients for level of care. Psychiatric hospitals assessment of level of care is documented by the attending physician utilizing an admission certification form and the continued need for psychiatric hospital level of care is documented by the attending physician and the social worker in progress notes.

f. Process for Level of Care Evaluation/Reevaluation. Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

Evaluation- A Registered Nurse from the Level of Care entity will be responsible for reviewing the most recent assessment performed in the medical facility. The nurse will use this information to screen each waiver applicant to determine whether they meet the criteria outlined in Appendix B-1-a and B-1-b. For participants transferring from ~~another 1915(c) waiver~~ ABI-RH, ABI-N or MFP-CL ~~-~~the Registered Nurse may either review the most recent level of care assessment performed for that waiver, or conduct an updated assessment to confirm that the participant meets a nursing facility or hospital level of care. The evaluation may be conducted in-person, telephone, video-conferencing and/or other electronic modalities with the participant.

Re-evaluation- A registered nurse from the contracted Level of Care entity makes an evaluation of each waiver participant. Information gathered for the re-evaluation of level of care is derived from ~~face to face~~ interviews done in-person, telephone, video-conferencing and/or other electronic modalities with the participants. Re-evaluations also ~~and~~ include~~s~~ a thorough evaluation of the client's individual circumstances and medical records.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

○	**Every three months**
○	**Every six months**

☑	**Every twelve months**
○	**Other schedule** *Specify* the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

☑	**The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
○	**The qualifications are different.** *Specify the qualifications:*

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care *(specify)*:

The Level of Care entity will maintain a database of waiver participants, the dates of level of care evaluations and dates for re-evaluation. They will be responsible for ensuring that the re-evaluation is triggered 60 days prior to the date it is due. Through the use of management reports registered nurses are provided with the data needed to ensure timely completion of reevaluation. The nurse documents the results of the re-evaluation using the MDS-HC, additional assessment questions and case notes. Level of Care entity reports to DDS include the date each Level of Care (LOC) re-evaluation is completed and the results of the level of care determination. ~~State monitoring is conducted on a sample of records to ensure that re-evaluations have been conducted in accordance with all requirements. In addition, MRC, in collaboration with DDS, will conduct periodic site visits and annual assessments of the Level of Care entity.~~

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Determinations of level of care are maintained by the Level of Care entity. Records are maintained for each waiver participant in accordance with 808 CMR 1.00 (the State's Division of Purchased Services regulations that describe the contract compliance, financial reporting, and auditing requirements applicable to state procurements of human and social services).

Quality Improvement: Level of Care

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: **Level of Care Assurance/Sub-assurances**

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-assurances:

a. Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.

i. Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	% of applicants who received an initial clinical eligibility assessment within 90 days of waiver application. (Number of individuals who received an initial clinical eligibility assessment within 90 days of waiver application/ Number of individuals who received an initial clinical eligibility assessment)
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify: **Level of Care Entity reports**	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☑ *Other Specify:*	☑ *Annually*	
	Level of Care Entity	☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☑ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

b Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.

i. Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	No longer needed in new QM system
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☑ *Less than 100% Review*

	☐ *Sub-State Entity*	☐ *Quarterly*		☐ *Representative Sample; Confidence Interval =*
	☑ *Other Specify:*	☐ *Annually*		
	No longer needed	☐ *Continuously and Ongoing*		☐ *Stratified: Describe Group:*
		☑ *Other Specify:*		
		No longer needed		☑ *Other Specify:*
				No longer needed

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☐ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☑ *Other Specify:*	☐ *Annually*
No longer needed	☐ *Continuously and Ongoing*
	☑ *Other Specify:*
	No longer needed

Add another Performance measure (button to prompt another performance measure)

c Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine the initial participant level of care.

i. Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed

statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	% of clinical determinations of "denial" that have been reviewed for appropriateness of denial. (Number of denials reviewed/ Number of denials)
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify: **Level of Care Entity reports**	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☑ *Other Specify:*	☑ *Annually*	
	Level of Care Entity	☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☑ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	% of applicants whose clinical eligibility assessment is documented in accordance with waiver requirements. (Number of applicants whose clinical eligibility assessment was documented in accordance with waiver requirements/ Number of applicants whose clinical eligibility assessment was documented)

Data Source *(Select one) (Several options are listed in the on-line application):*

If 'Other' is selected, specify: **Level of Care Entity reports**

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☑ *Other Specify:*	☑ *Annually*	
	Level of Care Entity	☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☑ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

ii *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

The Department of Developmental Services (DDS) and MassHealth are responsible for ensuring effective oversight of the waiver program, including administrative and operational functions performed by the Level of Care entity and the Administrative Service Organization. As problems are discovered with the management of the waiver program, the Administrative Services Organization, or waiver service providers, MassHealth/DDS will ensure that a corrective action plan is created, approved, and implemented within appropriate timelines. Timelines for remediation will be dependent on the nature and severity of the issue to be addressed. Further, MassHealth is responsible for identifying and analyzing trends related to the operation of the waiver and determining strategies to address quality- related issues.

ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Remediation-related Data Aggregation and Analysis (including trend identification)	***Responsible Party*** *(check each that applies)*	***Frequency of data aggregation and analysis:*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*
	☐ *Operating Agency*	☐ *Monthly*
	☐ *Sub-State Entity*	☐ *Quarterly*
	☐ *Other: Specify:*	☑ *Annually*
		☐ *Continuously and Ongoing*

		☐ *Other: Specify:*

c. Timelines

When the state does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

☑	**No**
○	**Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and

ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Once initial waiver eligibility has been determined, the Case Manager delivers a Recipient Choice Form to the participant (or legal representative) either in person, ~~or~~ by mail or electronically. This form includes written notification that the participant has been determined eligible for the waiver and offers the applicant the opportunity to choose between community-based or facility-based services. The participant indicates ~~his/her~~their preference on the Recipient Choice Form. The signed and dated form is maintained, for all waiver participants, by the case manager in the client record.

If the participant chooses to receive community-based services, the Case Manager informs the participant of the services available under the waiver as part of the person-centered service plan development process.

b. Maintenance of Forms. Per 45 CFR § 92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The Recipient Choice Form is maintained in the participant electronic record. ~~at the DDS' offices.~~

Appendix B-8: Access to Services by Limited English Proficient Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

MassHealth and the Department of Developmental Services (DDS) have developed multiple approaches to promote and ensure access to the waiver by Limited English Proficient persons. MassHealth eligibility notices and information regarding appeal rights are available in English and Spanish. In addition, these notices include a card instructing individuals in multiple languages that the information affects their health benefit, and to contact MassHealth Customer Service for assistance with translation.

Information about waiver eligibility and services is available in a number of languages and is posted on the MassHealth ABI/MFP Waivers webpage. Waiver denial notices include a card instructing individuals how to get assistance with translation. DDS also creates documents for participants in cognitively accessible formats. Case Managers are required to ensure the provision of services that are accessible to current and potential consumers. Accessible services are defined as those that address geographic, physical, and communication barriers so that consumers can be served according to their needs. Case Managers conduct outreach with materials in languages appropriate to their populations residing in the geographic service area. Case Managers also work collaboratively with minority community organizations that provide social services to identify individuals and families who may be eligible for waiver program services. DDS also has qualified Cultural Facilitators that may be accessed to assist in this process.

DDS attempts to ensure that employees are capable of speaking directly with consumers in their primary language and in cognitively accessible formats. When this is not possible, they arrange for interpreting services by either a paid interpreting service, a cultural facilitator or through an individual, such as a family member, designated by the consumer. DDS also provides access to TTY services for persons calling the agency.

~~DDS has developed multiple approaches to promote and help ensure access to the waiver for Limited English Proficient persons. One of the central methods is a contractual relationship established between DDS and the Multicultural Services Translation Center in order to provide written information to families and individuals with Limited English Proficiency in their primary language. This includes information such as applications, brochures, forms that need to be signed by individuals and family members/guardians, service plans, etc. General Waiver and service information needed by families is typically translated into six languages, other than English, which are most commonly spoken by residents in Massachusetts. This includes Spanish, Portuguese, Chinese, Russian, Vietnamese, and Khmer. The Translation Center has a roster of translators and interpreters for other languages as well so that DDS can respond to the need of families who speak languages beyond those listed previously, such as Haitian Creole or French. In addition to providing translated information, interpreters are made available when needed to enable individuals and family members to fully participate in planning meetings. These interpreters can be made available through the Multicultural Services Translation Center or through other local providers under state contract.~~

~~Another important method DDS utilizes to promote access to Waiver services is by working to build capacity among service providers to become more culturally responsive in their delivery of services. One central effort involves building in contractual requirements stipulating that providers must be responsive~~

~~to the specific ethnic, cultural, and linguistic needs of families in the geographic area they serve. It is expected that this is addressed in multiple ways including outreach efforts, hiring of bi-lingual and bicultural staff, providing information in the primary languages of the individuals and families receiving services, and developing working relationships with other multi-cultural community organizations in their communities. Another approach involves working collaboratively with minority community organizations that provide an array of social services to help in outreach to identify individuals and families who may be eligible for services from DDS and through the Waiver, as well as to build their capacity to provide waiver services. This is especially relevant in certain communities in which the presence of a "trusted member" from that particular ethnic and linguistic community is critical for individuals and families to be open to accepting disability related support services, such as in the Vietnamese, Cambodian, and Haitian communities.~~

~~DDS is committed to continue to develop and enhance efforts to provide meaningful access to services by individuals with Limited English Proficiency.~~

Appendix C: Participant Services

Appendix C-1/C-3: Summary of Services Covered and Services Specifications

C-1-a. Waiver Services Summary. Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service
Statutory Service	Prevocational Services
Statutory Service	Residential Habilitation
Statutory Service	Supported Employment
Other Service	Assisted Living Services
Other Service	Assistive Technology
Other Service	Community Based Day Supports (CBDS)
Other Service	Community Behavioral Health Support and Navigation
Other Service	Day Services
Other Service	Home Accessibility Adaptations
Other Service	Individual Support and Community Habilitation
Other Service	Occupational Therapy
Other Service	Orientation and Mobility Services
Other Service	Peer Support
Other Service	Physical Therapy
Other Service	Residential Family Training
Other Service	Shared Living-24 Hour Supports
Other Service	Skilled Nursing
Other Service	Specialized Medical Equipment
Other Service	Speech Therapy
Other Service	Transitional Assistance Services
Other Service	Transportation

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification
Service Type:
Statutory Service
Service:
Prevocational Services
☐ Service is included in approved waiver. There is no change in service specifications. ☑ Service is included in approved waiver. The service specifications have been modified. ☐Service is not included in approved waiver.
Service Definition (Scope)**:**
Prevocational Services comprises a range of learning and experiential type activities that prepare a participant for paid or unpaid employment in an integrated, community setting. Services are not job-task oriented but instead, aimed at a generalized result (e.g. attention span, motor skills). The service may include teaching such concepts as attendance, task completion, problem solving and safety as well as social skills training, improving attention span, and developing or improving motor skills. Basic skill-building activities are expected to specifically involve strategies to enhance a participant's employability in integrated, community settings. The amount, duration and scope of Prevocational Services provided to a participant is based on an assessment of the participant's pre-employment needs that arise as a result of ~~his or her~~their functional limitations and/or conditions, including services that enable the participant to acquire, improve, retain/maintain, and prevent deterioration of functioning consistent with the participant's interests, strengths, priorities, abilities and capabilities. Services are reflected in the participant's individualized service plan and are directed to address habilitative or rehabilitative rather than explicit employment objectives. Prevocational services may be provided one-to-one or in a group format. This service may be provided as a site-based service, in community settings or in a combination of these settings and must include integrated community activities that support the development of vocational skills. This service may be provided remotely via telehealth based on the participant's needs, preferences, and goals as determined during the person-centered planning process and reviewed by the Case Manager during each scheduled reassessment as outlined in Appendix D-2-a. This service may be delivered remotely via telehealth 100% of the time. The methods and minimum frequency with which participants will receive face-to-face contact to ensure health and welfare are described in Appendix D-2-a. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative	☐	Legal Guardian

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Prevocational Services Agencies

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Prevocational Services Agencies			Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following: - Education, Training, Supervision: Providers are responsible for ensuring staff are trained on: - Applicable regulations and policies governing waiver service delivery and the principles of participant-centered, community-based care. - Potential cognitive and/or mental health issues as well as physical needs of participants with disabilities - All aspects of their job duties, including handling a range of potential emergency situations. Agencies must have established procedures for appraising staff performance and for effectively modifying poor performance where it exists. - Adherence to Continuous QI Practices: Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual participants by providing effective, efficient services. Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required.

			- Availability/Responsiveness: Providers must be able to initiate services with little or no delay in the geographical areas they designate. - Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with applicable laws and policies. - Policies/Procedures: Providers must have policies and procedures that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific requirements for providers can include provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H. - Agencies must ensure that staff who provide Prevocational services: have been Criminal Offender Record Information (CORI) checked, have a

			College degree plus experience in providing community-based services to individuals with disabilities, or at least two years comparable community-based, life or work experience providing services to individuals with disabilities; can handle emergency situations; can set limits, and communicate effectively with participants, families, other providers and agencies; have ability to meet legal requirements in protecting confidential information. Physical Plant: - Understanding and compliance with all required policies, procedures, and physical plant standards relevant to the community setting as established by MRC. - Demonstrated compliance with health and safety, accessibility standards and the ADA, as applicable. Providers licensed, certified and qualified by DDS in accordance with 115 CMR 7.00 (Department of Developmental Services (DDS) regulations for all DDS supports and services provided by public and private providers and those services subject to regulation by the Massachusetts Rehabilitation Commission, which provide social and pre-vocational supports and work training) will be considered to have met these standards.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Prevocational Services Agencies	Administrative Service Organization	Every 2 years

Service Specification
Service Type:
Statutory Service
Service:

Residential Habilitation

☐ Service is included in approved waiver. There is no change in service specifications.

☑ Service is included in approved waiver. The service specifications have been modified.

☐Service is not included in approved waiver.

Service Definition (Scope)**:**

Residential Habilitation consists of ongoing services and supports, by paid staff in a provider-operated residential setting, that are designed to assist individuals to acquire, maintain or improve the skills necessary to live in a non-institutional setting. Residential Habilitation provides individuals with daily staff intervention for care, supervision and skills training in activities of daily living, home management and community integration in a qualified provider-operated residence with 24 hour staffing. Residential Habilitation includes individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports (such as safety sign recognition and money management), and social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to their needs. Residential Habilitation also includes personal care and protective oversight and supervision. This service may include the provision of medical and health care services that are integral to meeting the daily needs of participants. Transportation between the participant's place of residence and other service sites or places in the community may be provided as a component of residential habilitation services and included in the rate paid to providers of residential habilitation services.

Provider owned or leased facilities where Residential Habilitation services are furnished must be compliant with the Americans with Disabilities Act and must meet the applicable requirements of the Community Rule (42 CFR 441.301(c)(4)). Residential Habilitation will be provided in settings with at least two and no more than four individuals residing in the setting and receiving the service. Settings with more than four individuals require state approval.

Residential Habilitation is not available to individuals who live with their immediate family unless the immediate family member (grandparent, parent, sibling or spouse) is also eligible for Residential Habilitation supports and had received prior authorization, as applicable for Residential Habilitation. Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for Residential Habilitation is specified in Appendix I-5. Payment is not made, directly or indirectly, to members of the individual's family, except as provided in Appendix C-2.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative	☐ Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Residential Habilitation Service Agencies

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Residential Habilitation Service Agencies	115 CMR 7.00 (Department of Developmental Services Standards for all Services and Supports) and 115 CMR 8.00 (Department of Developmental Services Certification, Licensing and Enforcement Regulations) or 104 CMR Chapter 28 (Department of Mental Health regulations governing Licensing and Operational Standards for Community Programs).	Residential Habilitation Provider employees must have a High School diploma, GED or relevant equivalencies or competencies.	Residential Habilitation Provider employees must possess appropriate qualifications as evidenced by interview(s), two personal or professional references and a Criminal Offender Records Inquiry (CORI), be age 18 years or older, ~~be knowledgeable about what to do in an emergency; be knowledgeable about how to report abuse and neglect,~~ have the ability to communicate effectively in the language and communication style of the participant, maintain confidentiality and privacy of the consumer, respect and accept different values, nationalities, races, religions, cultures and standards of living. Policies/Procedures: Providers must have policies that apply to and comply with the applicable standards under 105 CMR 155.000 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a home health agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations).

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Residential Habilitation Service Agencies	Department of Developmental Services (DDS) Office of Quality Enhancement, Survey and Certification staff.	Every 2 years

Service Specification
Service Type:
Statutory Service
Service:
Supported Employment
☐ Service is included in approved waiver. There is no change in service specifications. ☑ Service is included in approved waiver. The service specifications have been modified. ☐Service is not included in approved waiver.
Service Definition (Scope)**:**
Supported employment services consist of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting. Supported employment may include assisting the participant to locate a job or develop a job on behalf of the participant. Supported employment is conducted in a variety of settings, particularly work sites where persons without disabilities are employed. This service may be provided remotely via telehealth based on the participant's needs, preferences, and goals as determined during the person-centered planning process and reviewed by the Case Manager during each scheduled reassessment as outlined in Appendix D-2-a. This service may be delivered remotely via telehealth 100% of the time. The methods and minimum frequency with which participants will receive face-to-face contact to ensure health and welfare are described in Appendix D-2-a. Supported employment includes activities needed to sustain paid work by participants, including supervision and training. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting. Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program; 2. Payments that are passed through to users of supported employment programs; or 3. Payments for training that is not directly related to an individual's supported employment program.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service is not for use to provide continuous long-term 1:1 on the job support to enable an individual to complete work activities.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative	☐ Legal Guardian

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Community-Based Employment Services Agencies

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Community-Based Employment Services Agencies			Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has demonstrated the experience and ability to successfully provide four components of supported employment programs, including Assessment, Placement, Initial Employment Supports and Extended Employment Supports, as specified by the MassHealth agency and to meet, at a minimum, the following requirements: Program: - Experience providing supported employment services - Demonstrated experience and/or willingness to work effectively with the MassHealth agency or its designee, with the Case Managers responsible for oversight and monitoring of the participants receiving these services, with the participants and their family/significant others; - Adequate organizational structure to support the delivery and supervision of supported employment services, including: - Ability to appropriately assess participants needs; obtain evaluative consultations; provide job development, matching and placement services; ensure necessary supports for employment (coaching/counseling/ training, transportation, accommodations, assistive technology); provide initial and extended supports to maintain job stability and retention, as appropriate; and respond to crisis situations; - Demonstrated ability to produce timely, complete and quality documentation including but not limited to assessments,

			incident reports, progress reports and program-specific service plans - Demonstrated compliance with health and safety standards, as applicable. - Demonstrated ability to work with and have established linkages with community employers; proven participant marketing/employer outreach strategies; developed employer education materials; plan for regular and on-going employer communication - Demonstrated compliance with health and safety, and Department of Labor standards, as applicable. Policies/Procedures: Providers must have policies that apply to and comply with the applicable standards under 105 CMR 155.000 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a home health agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as

			well with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific requirements for providers can include provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H. Staff and Training: - Experience recruiting and maintaining qualified staff; assurance that all staff will be CORI checked; policies/practices which ensure that: - There is a team approach to service delivery - Program management and staff meet the minimum qualifications established by the MassHealth agency and understand the principals of participant choice, as it relates to those with disabilities. Quality: - Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required. Providers licensed, certified and qualified by DDS in accordance with 115 CMR 7.00 (Department of Developmental Services (DDS) regulations for all DDS supports and services provided by public and private providers and those services subject to regulation by the Massachusetts Rehabilitation Commission, which provide social and pre-vocational supports and work training) will be considered to have met these standards.
Verification of Provider Qualifications			

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Community-Based Employment Services Agencies	Administrative Service Organization	Every 2 years

Service Specification
Service Type:
Other Service
Service:
Assisted Living Service
☐ Service is included in approved waiver. There is no change in service specifications. ☑ Service is included in approved waiver. The service specifications have been modified. ☐Service is not included in approved waiver.
Service Definition (Scope)**:**
These services consist of personal care and supportive services (homemaker, chore, personal care services, meal preparation) that are furnished to waiver participants who reside in an assisted living residence (ALR) that meets the applicable requirements of the Community Rule (42 CFR 441.301(c)(4)), and includes 24-hour on-site response capability to meet scheduled or ~~unpredictable~~ unscheduled resident needs and to provide supervision, safety and security. Services also may include social and recreational programming, and medication assistance (consistent with ALR Certification and to the extent permitted under State law). Nursing and skilled therapy services are incidental rather than integral to the provision of Assisted Living Services. Intermittent skilled nursing services and therapy services may be provided to the extent allowed by applicable regulations. Assisted Living Services do not include, and payment will not be made for, 24-hour skilled care. ~~The following waiver services are not available to participants receiving Assisted Living Services: chore, homemaker, personal care, home health aide, and supportive home care aide.~~ Duplicative waiver and state plan services are not available to participants receiving Assisted Living Services. Participants may only receive one residential support service at a time. Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed		
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative	☐	Legal Guardian

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Assisted Living Service Agencies

Provider Qualifications			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Assisted Living Service Agencies		Certified by the Executive Office of Elder Affairs in accordance with 651 CMR 12.00 (Department of Elder Affairs regulations describing the certification procedures and standards for Assisted Living Residences in Massachusetts).	Must meet the applicable requirements of the Community Rule (42 CFR 441.301(c)(4))

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Assisted Living Service Agencies	Administrative Service Organization	Every 2 years

Service Specification
Service Type
Other Service
Service Name: Assistive Technology
☐ Service is included in approved waiver. There is no change in service specifications. ☐ Service is included in approved waiver. The service specifications have been modified. ☑ Service is not included in approved waiver.
Service Definition (Scope)**:**
This service has two components: Assistive Technology devices and Assistive Technology evaluation and training. These components are defined as follows: Assistive Technology devices - an item, piece of equipment, or product system that is used to develop, increase, maintain, or improve functional capabilities of participants, and to support the participant to achieve goals identified in their Plan of Care. Assistive Technology devices can be used to enable the participant to engage in telehealth. Assistive Technology devices can be acquired commercially or modified, customized, engineered or otherwise adapted to meet the individual's specific needs, including design and fabrication. In addition to the cost of Assistive Technology device purchase, lease, or other acquisition costs, this service component covers maintenance and repair of Assistive Technology devices and rental of substitute Assistive Technology devices during periods of repair. This service includes device installation and set up costs but excludes installation and set-up and ongoing provision fees related to internet service.

Assistive Technology evaluation and training – the evaluation of the Assistive Technology needs of the participant, i.e. functional evaluation of the impact of the provision of appropriate Assistive Technology devices and services to the participant in the customary environment of the participant; the selection, customization and acquisition of Assistive Technology devices for participants; selection, design, fitting, customization, adaption, maintenance, repair, and/or replacement of Assistive Technology devices; coordination and use of necessary therapies, interventions, or services with Assistive Technology devices that are associated with other services contained in the Plan of Care; training and technical assistance for the participant, and, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants. Assistive Technology must be authorized by the Case Manager as part of the Plan of Care. The Case Manager will explore with the participant/legal guardian the use of the Medicaid State Plan. Waiver funding shall only be used for assistive technology that is specifically related to the functional limitation(s) caused by the participant's disability. The evaluation and training component of this service may be provided remotely via telehealth based on the professional judgement of the evaluator and the needs, preferences, and goals of the participant as determined during the person-centered planning process and reviewed by the Case Manager during each scheduled reassessment as outlined in Appendix D-2-a.

Assistive Technology must meet the Underwriter's Laboratory and/or Federal Communications Commission requirements, where applicable, for design, safety, and utility.

There must be documentation that the item purchased is appropriate to the participant's needs. Any Assistive Technology item that is available through the State Plan must be purchased through the State Plan; only items not covered by the State Plan may be purchased through the Waiver.

This service includes purchase, lease, or other acquisition costs of cell phones, tablets, computers, and ancillary equipment necessary for the operation of the Assistive Technology devices that enable the individual to participate in telehealth. These devices are not intended for purely diversional/recreational purposes.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Participants may not receive duplicative devices through this service and either the Transitional Assistance Service or the Specialized Medical Equipment Service. The Assistive Technology evaluation includes identification of technology already available and assesses whether technology modifications or a new device is appropriate based on demonstrated need.

Service Delivery Method *(check each that applies)*:	☑	Participant-directed as specified in Appendix E	☑	Provider managed

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☑	Relative	☐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	☑	Individual. List types:	☑	Agency. List the types of agencies:
	Individual Assistive Technology Provider		Assistive Technology Agencies	

		Assistive Technology Device Provider

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Assistive Technology Agencies			Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following: - Providers shall ensure that individual workers employed by the agency have been CORI checked and are able to perform assigned duties and responsibilities. - Providers of assistive technology must ensure that all devices and accessories have been examined and/or tested by Underwriters Laboratory (or other appropriate organization), and comply with FCC regulations, as appropriate. Staff providing services must have: - Bachelor's degree in a related technological field and at least one year of demonstrated experience providing adaptive technological assessment or training; or - A bachelor's degree in a related health or human service field with at least two years of demonstrated experience providing adaptive technological assessment or training; or - Three years of demonstrated experience providing adaptive technological assessment or training. Individuals providing services must also have: - Knowledge and experience in the evaluation of the needs of an individual with a disability, including functional evaluation of the individual in the individual's customary environment. - Knowledge and experience in the purchasing, or otherwise providing for the acquisition of assistive technology devices by individuals with disabilities. - Knowledge and/or experience in selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices. - Knowledge and/or experience in coordinating and using other therapies, interventions, or services with assistive technology devices. - Knowledge and/or experience in training or providing technical assistance for an individual with

			disabilities, or, when appropriate, the family of an individual with disabilities or others providing support to the individual. - Knowledge and/or experience in training and/or providing technical assistance for professionals or other individuals who provide services to or are otherwise substantially involved in the major life functions of individuals with disabilities. In addition, providers licensed, certified and qualified by DDS in accordance with 115 CMR 7.00 (Department of Developmental Services (DDS) regulations for all DDS supports and services provided by public and private providers and those services subject to regulation by the Massachusetts Rehabilitation Commission, which provide social and pre-vocational supports and work training) will be considered to have met these standards.
Individual Assistive Technology Provider			Individuals who provide Assistive Technology services must have responded satisfactorily to the Waiver provider enrollment process and must meet requirements for individuals in such roles, including, but not limited to must: have been CORI checked and communicate effectively with participants, families, other providers and agencies; have ability to meet legal requirements in protecting confidential information. Individuals providing services must have: - Bachelor's degree in a related technological field and at least one year of demonstrated experience providing adaptive technological assessment or training; or - A bachelor's degree in a related health or human service field with at least two years of demonstrated experience providing adaptive technological assessment or training; or - Three years of demonstrated experience providing adaptive technological assessment or training. Individuals providing services must also have: - Knowledge and experience in the evaluation of the needs of an individual with a disability, including functional evaluation of the individual in the individual's customary environment. - Knowledge and experience in the purchasing, or otherwise providing for the acquisition of assistive technology devices by individuals with disabilities.

			- Knowledge and/or experience in selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices. - Knowledge and/or experience in coordinating and using other therapies, interventions, or services with assistive technology devices. - Knowledge and/or experience in training or providing technical assistance for an individual with disabilities, or, when appropriate, the family of an individual with disabilities or others providing support to the individual. - Knowledge and/or experience in training and/or providing technical assistance for professionals or other individuals who provide services to or are otherwise substantially involved in the major life functions of individuals with disabilities. In addition, individuals licensed, certified and qualified by DDS in accordance with 115 CMR 7.00 (Department of Developmental Services (DDS) regulations for all DDS supports and services provided by public and private providers and those services subject to regulation by the Massachusetts Rehabilitation Commission, which provide social and pre-vocational supports and work training) will be considered to have met these standards.
Assistive Technology Device Provider			Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following: - Providers shall ensure that individual workers employed by the agency have been CORI checked and are able to perform assigned duties and responsibilities. - Providers of assistive technology must ensure that all devices and accessories have been examined and/or tested by Underwriters Laboratory (or other appropriate organization), and comply with FCC regulations, as appropriate. In addition, providers licensed, certified and qualified by DDS in accordance with 115 CMR 7.00 (Department of Developmental Services (DDS) regulations for all DDS supports and services provided by public and private providers and those

			services subject to regulation by the Massachusetts Rehabilitation Commission, which provide social and pre-vocational supports and work training) will be considered to have met these standards.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Assistive Technology Agencies	Administrative Service Organization	Every 2 years
Individual Assistive Technology Provider	Administrative Service Organization	Every 2 years
Assistive Technology Device Provider	Administrative Service Organization	Every 2 years

Service Specification
Service Type:
Other Service
Service:
Community Based Day Supports
☐ Service is included in approved waiver. There is no change in service specifications. ☑ Service is included in approved waiver. The service specifications have been modified. ☐Service is not included in approved waiver.
Service Definition (Scope)**:**
Community Based Day Supports (CBDS) is designed to enable an individual to enrich ~~his or her~~their life and enjoy a full range of community activities by providing opportunities for developing, enhancing, and maintaining competency in personal, social interactions and community integration. The service may include career exploration, including assessment of interests through volunteer experiences or situational assessments; community integration experiences to support fuller participation in community life; development and support of activities of daily living and independent living skills, socialization experiences and enhancement of interpersonal skills and pursuit of personal interests and hobbies. The service is intended for individuals of working age who may be on a pathway to employment, a supplemental service for individuals who are employed part-time and need a structured and supervised program of services during the time that they are not working, and for individuals who are of retirement age. Using a small group model, CBDS provides a flexible array of individualized supports through community activities that promote socialization, peer interaction and community integration.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative	☐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Rehabilitation Agencies
				Human Service Agencies

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Rehabilitation Agencies			Any not-for-profit or proprietary organization that responds satisfactorily to the waiver provider enrollment process, which includes meeting requirements for staffing qualifications and training, and all prescribed operational policies and procedures, including, but not limited to: Program: - Understanding and compliance with all required policies, and procedures - Experience providing functional, community-based services and living skills training and understanding of the philosophy of maximizing independence, participant participation, community integration and a comprehensive blend of services; - Demonstrated experience and/or willingness to work effectively with the MassHealth agency or its designee and with the Case Managers responsible for oversight and monitoring of the participants receiving these services; - Adequate organizational structure to support the delivery and supervision of day services in the community, including: - Ability to plan and deliver services - Demonstrated ability to produce timely, complete and quality documentation including but not limited to assessments, incident reports, progress reports and program-specific service plans

			Policies/Procedures: Providers must have policies that apply to and comply with the applicable standards under 105 CMR 155.000 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a home health agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). Staff and Training: - Individuals who provide CBDS services must meet all requirements for individuals in such roles, including, but not limited to: have been CORI checked, have a college degree plus experience in providing community-based services to individuals with disabilities, or at least five years comparable work experience providing community-based services to individuals with disabilities; can handle emergency situations; can set limits, and communicate effectively with participants, families, other providers and agencies; have ability to meet legal requirements in protecting confidential information; and certification in CPR is required. - Demonstrates a team approach to service delivery including the ability to define, track and monitor service

			interventions that meet participant goals and objectives - Ability to access relevant clinical support as needed - Experience recruiting and maintaining qualified staff; assurance that all staff will be CORI checked; policies/practices which ensure that: - Program management and staff meet the minimum qualifications established by the MassHealth agency and understand the principles of participant choice Quality: - Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required. Compliance with the licensure and/or certification standards of another Executive Office of Health and Human Services agency may be substituted for the above qualifications. For example Department of Developmental Services requirements at 115 CMR 7.00 & 8.00 (Department of Developmental Services (DDS) regulations for all DDS supports and services provided by public and private providers and those services subject to regulation by the Massachusetts Rehabilitation Commission, which provide social and pre-vocational supports and work training) or Department of Mental Health requirements at 104 CMR Subpart B (Department of Mental Health regulations for licensing and operational standards for mental health related community programs and which address protection from mistreatment and physical restraints) may be substituted for the above qualifications.
Human Service Agencies			Any not-for-profit or proprietary organization that responds satisfactorily to the waiver provider enrollment

			process, which includes meeting requirements for staffing qualifications and training, and all prescribed operational policies and procedures, including, but not limited to: Program: - Understanding and compliance with all required policies, and procedures - Experience providing functional, community-based services and living skills training and understanding of the philosophy of maximizing independence, participant participation, community integration and a comprehensive blend of services; - Demonstrated experience and/or willingness to work effectively with the MassHealth agency or its designee and with the Case Managers responsible for oversight and monitoring of the participants receiving these services; - Adequate organizational structure to support the delivery and supervision of services in the community, including: - Ability to plan and deliver services - Demonstrated ability to produce timely, complete and quality documentation including but not limited to assessments, incident reports, progress reports and program-specific service plans Staff and Training: - Individuals who provide CBDS services must meet all requirements for individuals in such roles, including, but not limited to: have been CORI checked, have a college degree plus experience in providing community-based services to individuals with disabilities, or at least five years comparable work experience providing community-based services to individuals with disabilities; can handle emergency situations; can set limits, and communicate effectively with participants, families, other providers and agencies; have ability to meet legal requirements in protecting confidential

			information; and certification in CPR is required. Policies/Procedures: Providers must have policies that apply to and comply with the applicable standards under 105 CMR 155.000 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a home health agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). - Provider agencies must demonstrate: - A team approach to service delivery including the ability to define, track and monitor service interventions that meet participant goals and objectives; - Ability to access relevant clinical support as needed; - Experience recruiting and maintaining qualified staff, including assurance that all staff will be CORI checked; - Policies/practices which ensure that program management and staff meet the minimum qualifications established by the MassHealth agency and understand the principles of participant choice; and that individuals who provide CBDS services receive effective training in all

			aspects of their job duties, including handling emergency situations. Quality: - Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required. Compliance with the licensure and/or certification standards of another Executive Office of Health and Human Services agency may be substituted for the above qualifications. For example Department of Developmental Services requirements at 115 CMR 7.00 & 8.00 (Department of Developmental Services (DDS) regulations for all DDS supports and services provided by public and private providers and those services subject to regulation by the Massachusetts Rehabilitation Commission, which provide social and pre-vocational supports and work training) or Department of Mental Health requirements at 104 CMR Subpart B (Department of Mental Health regulations for licensing and operational standards for mental health related community programs and which address protection from mistreatment and physical restraints) may be substituted for the above qualifications.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Rehabilitation Agencies	Administrative Service Organization	~~Annually~~Every 2 years
Human Service Agencies	Administrative Service Organization	~~Annually~~Every 2 years

Service Specification
Service Type:
Other Service
Service:
Community Behavioral Health Support and Navigation

☐ Service is included in approved waiver. There is no change in service specifications.

☑ Service is included in approved waiver. The service specifications have been modified.

☐Service is not included in approved waiver.

Service Definition (Scope)**:**

Community Behavioral Health Support and Navigation includes an array of services delivered by community based, mobile, paraprofessional staff, supported by a clinical supervisor, to participants with behavioral health needs whose psychiatric diagnosis or substance use disorder(s) interferes with their ability to access essential medical and behavioral health services. The services provided are tailored to the needs of the individual and are designed to ensure that the participant has access to and in fact utilizes needed behavioral health services. Community Behavioral Health Support and Navigation does not include clinical treatment services, but rather provides outreach and support services to enable participants to utilize clinical treatment services and other supports. Community Behavioral Health Support and Navigation assists the participant with attaining the goals in his/her plan of care, and works to mitigate barriers to doing so. This service is primarily delivered in person; telehealth may be used to supplement the scheduled in-person service based on the participant's needs, preferences, and goals as determined during the person-centered planning process and reviewed by the Case Manager during each scheduled reassessment as outlined in Appendix D-2-a.

Community Behavioral Health Support and Navigation services are designed to be maximally flexible in supporting participants to implement the goals in their plan of care and attain the skills and resources needed to successfully maintain community tenure. Such services may include:
- Fostering empowerment, recovery, and wellness, including developing recovery strategies, identifying and assisting participants in accessing self-help options, and creating crisis prevention plans and relapse prevention plans;
- Assisting participants in improving their daily living skills so they are able to perform them independently or access services to support them in doing so; - Supporting service exploration and linkage;
- Providing temporary assistance with transportation to essential medical and behavioral health appointments while transitioning to community-based transportation resources (e.g., public transportation resources, PT-1 forms, etc.)
- Assisting with connecting the participant to necessary behavioral health and other health care services (including, as applicable, supporting engagement with coordination provided by the participant's ACO or MCO);
- Providing linkages to recovery-oriented peer support and/or self-help supports and services;
- Assisting with self-advocacy skills to improve communication and participation in treatment/service planning discussions and meetings; and
- Collaborating with Emergency Services Programs/Mobile Crisis Intervention (ESP/MCIs) and/or outpatient providers; including working with ESP/MCIs to develop, revise and/or utilize participant crisis prevention plans and/or safety plans.

Community Behavioral Health Support and Navigation services may not duplicate, and are expected to complement, other waiver and State Plan services that are being utilized by the individual and support the participant's attainment of ~~his/her~~their plan of care goals.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative	☐ Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Community Behavioral Health Support and Navigation Providers

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Community Behavioral Health Support and Navigation Providers	Services are provided by agencies that provide mental health or substance use disorder services and are licensed within the Commonwealth of Massachusetts.		Agency Staffing and Supervision Requirements: - Agencies providing Community Behavioral Health Support and Navigation must employ a multi-disciplinary staff with established experience, skills, and training in the acute treatment of mental health and co-occurring mental health and substance use conditions, including a minimum of one fulltime master's or doctorate-level, licensed behavioral health clinician responsible for operation of the program and supervision of the staff. - In addition, there must be a psychiatric clinician available for psychiatric phone consultation within 15 minutes of request and for a face-to-face evaluation within 60 minutes of request, when clinically indicated. - Agencies providing Community Behavioral Health Support and Navigation must ensure that the service is accessible to participants seven days per week. An answering machine or answering service directing callers to call 911 or the ESP/MCI, or to go to a hospital emergency department (ED) does not meet this requirement. Individual Staff Requirements: Individuals who provide Community Behavioral Health Support and Navigation are mobile, community-based staff that must meet requirements for individuals in such roles, including, but not limited to: - have been CORI checked; - Bachelor's degree in a Human Services field and experience working in community settings with individuals with disabilities who have behavioral health needs;

			- training in and ability to handle emergency situations; - can set limits and communicate effectively with participants, families, other providers and agencies; - have ability to meet legal requirements in protecting confidential information; and - certification in CPR is required. Policies/Procedures: Providers must have policies that apply to and comply with the applicable standards under 105 CMR 155.000 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a home health agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific

			requirements for providers can include provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H. Agencies qualified as providers of the following services through the applicable state agency or other designated entity are considered to have met the above qualification requirements: - Community Based Family Supports (CBFS), through the Department of Mental Health (DMH) - Community Support Program (CSP) through MassHealth or a MassHealth-contract Managed Care Organization (MCO), Accountable Care Organization (ACO), or Integrated Care Organization (One Care) - Program of Assertive Community Treatment (PACT), through DMH - Behavioral Health Community Partners (BH CPs), through MassHealth

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Community Behavioral Health Support and Navigation Providers	Administrative Service Organization	Every 2 years

Service Specification
Service Type:
Other Service
Service:
Day Services
☐ Service is included in approved waiver. There is no change in service specifications. ☑ Service is included in approved waiver. The service specifications have been modified. ☐Service is not included in approved waiver.
Service Definition (Scope)**:**
Day services/supports provide for structured day activity typically for individuals with pervasive and extensive support needs who are not ready to join the general workforce, or who are employed part-time and need a structured and supervised program of services during the time that they are not working, or who are of retirement age. Day Services are individually designed around consumer choice and preferences with a focus on improvement or maintenance of the person's skills and their ability to live as independently as possible in the

community. Day Services often include assistance to learn activities of daily living and functional skills; language and communication training; compensatory, cognitive and other strategies; interpersonal skills; recreational/socialization skills and other skills training to prepare the individual to undertake various community inclusion activities. This service may reinforce some aspects of other waiver and state plan services by allowing individuals to continue to strengthen skills, which are necessary for greater independence, productivity and community inclusion. Day Services are provided in a provider operated setting in the community and not in a participant's residence, and do not duplicate any services under the state plan.

This service is primarily delivered in person; telehealth may be used to supplement the scheduled in-person service based on the participant's needs, preferences, and goals as determined during the person-centered planning process and reviewed by the Case Manager during each scheduled reassessment as outlined in Appendix D-2-a

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative	☐ Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Human Service Agencies
				Rehabilitation Facilities

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Human Service Agencies			Any not-for-profit or proprietary organization that responds satisfactorily to the waiver provider enrollment process, which includes meeting requirements for staffing qualifications and training, and all prescribed operational policies and procedures, including, but not limited to: Program and Physical Plant: - Understanding of and compliance with all required policies, procedures, and physical plant standards - Experience providing functional, community-based services and living skills training and understanding of the philosophy of maximizing independence, participant participation, community integration and a comprehensive blend of services;

			- Demonstrated experience and/or willingness to work effectively with the MassHealth agency or its designee and with the Case Managers responsible for oversight and monitoring of the participants receiving these services; - Adequate organizational structure to support the delivery and supervision of day services, including:- - Ability to plan and deliver services in the prescribed settings - Demonstrated ability to produce timely, complete and quality documentation including but not limited to assessments, incident reports, progress reports and program-specific service plans - Demonstrated compliance with health and safety, accessibility standards and the ADA, as applicable. Staff and Training: - Demonstrates a team approach to service delivery including the ability to define, track and monitor service interventions that meet participant goals and objectives - Ability to access relevant clinical support as needed - Experience recruiting and maintaining qualified staff; assurance that all staff will be CORI checked; policies/practices which ensure that: - Program management and staff meet the minimum qualifications established by the MassHealth agency and understand the principles of participant choice. Quality: • Ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee; ability to provide program and participant quality data and reports. Compliance with the licensure and/or certification standards of another Executive Office of Health and Human

			Services agency, for example Department of Developmental Services requirements at 115 CMR 7.00 & 8.00 (Department of Developmental Services (DDS) regulations for all DDS supports and services provided by public and private providers and those services subject to regulation by the Massachusetts Rehabilitation Commission, which provide social and pre-vocational supports and work training) or Department of Mental Health requirements at 104 CMR Subpart B (Department of Mental Health regulations for licensing and operational standards for mental health related community programs and which address protection from mistreatment and physical restraints) may be substituted for the above qualifications. Policies/Procedures: Providers must have policies that apply to and comply with the applicable standards under 105 CMR 155.000 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a home health agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). Telehealth providers must comply with the requirements of the Health Insurance

			Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific requirements for providers can include provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H.
Rehabilitation Facilities			Any not-for-profit or proprietary organization that responds satisfactorily to the waiver provider enrollment process, which includes meeting requirements for staffing qualifications and training, and all prescribed operational policies and procedures, including, but not limited to: Program and Physical Plant: • Understanding and compliance with all required policies, procedures, and physical plant standards • Experience providing functional, community-based services and living skills training and understanding of the philosophy of maximizing independence, participant participation, community integration and a comprehensive blend of services for this population; • Demonstrated experience and/or willingness to work effectively with the MassHealth agency or its designee and with the case managers responsible for oversight and monitoring of the participants receiving these services; • Adequate organizational structure to support the delivery and supervision of day services, including: - Demonstrated ability to plan and deliver services in the prescribed settings - Demonstrated ability to produce timely,

			complete and quality documentation including but not limited to assessments, incident reports, progress reports and program-specific service plans - Demonstrated compliance with health and safety, accessibility standards and the ADA, as applicable. Policies/Procedures: Providers must have policies that apply to and comply with the applicable standards under 105 CMR 155.000 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a home health agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific requirements for providers can include

			provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H. Staff and Training: • Demonstrates a team approach to service delivery including the ability to define, track and monitor service interventions that meet participant goals and objectives • Ability to access relevant clinical support as needed • Experience recruiting and maintaining qualified staff; assurance that all staff will be CORI checked; policies/practices which ensure that: - There is a team approach to service delivery - Program management and staff meet the minimum qualifications established by the MassHealth agency and understand the principles of participant choice. Quality: • Ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee; ability to provide program and participant quality data and reports. Compliance with the licensure and/or certification standards of another Executive Office of Health and Human Services agency, for example Department of Developmental Services requirements at 115 CMR 7.00 & 8.00 (Department of Developmental Services (DDS) regulations for all DDS supports and services provided by public and private providers and those services subject to regulation by the Massachusetts Rehabilitation Commission, which provide social and pre-vocational supports and work training) or Department of Mental Health requirements at 104 CMR Subpart B (Department of Mental Health

			regulations for licensing and operational standards for mental health related community programs and which address protection from mistreatment and physical restraints) may be substituted for the above qualifications.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Human Service Agencies	Administrative Service Organization	~~Annually~~Annual for the first year and every 2 years thereafter
Rehabilitation Facilities	Administrative Service Organization	~~Annually~~Annual for the first year and every 2 years thereafter

Service Specification
Service Type:
Other Service
Service:
Home Accessibility Adaptations
☐ Service is included in approved waiver. There is no change in service specifications. ☑ Service is included in approved waiver. The service specifications have been modified. ☐Service is not included in approved waiver.
Service Definition (Scope)**:**
Those physical adaptations to the private residence of the participant or the participant's family, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include, but are not limited to, the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. Those physical adaptations to the private residence of the participant or the participant's family, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include, but are not limited to, the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. This service may also include architectural services to develop drawings and narrative specifications for architectural adaptations, adaptive equipment installation, and related construction as well as subsequent site inspections to oversee the completion of adaptations and conformance to local and state building codes, acceptable building trade standards and bid specifications. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are

excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

Also excluded are those modifications which would normally be considered the responsibility of the landlord. Home accessibility modifications may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.

The assessment and evaluation component of the home and adaptations service may be provided remotely via telehealth based on the professional judgement of the evaluator and the needs, preferences, and goals of the participant as determined during the person-centered planning process and reviewed by the Case Manager during each scheduled reassessment as outlined in Appendix D-2-a.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Lifetime limit of $50,000 per participant. Requests for exceptions to this limit must demonstrate that the exception is essential to the health and safety of the participant and must be approved by DDS, MRC and MassHealth.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative	☐ Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)***:**	☑	Individual. List types:	☑	Agency. List the types of agencies:
	Architect/Designer		Home Accessibility Adaptations Agencies	
	Home Accessibility Adaptation Provider (Self-Employed)		Architect/Designer Agencies	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Accessibility Adaptations Agencies	If the scope of work involves home modifications, agencies and individuals employed by the agencies must possess any licenses/certifications required by the state (e.g., Home Improvement Contractor, Construction Supervisor License, Plumbers license, etc.)		Any not-for-profit or proprietary organization that becomes qualified through the MRC open procurement process and as such, successfully demonstrates, at a minimum, the following: Providers shall ensure that individual workers employed by the agency have been CORI checked, and are able to perform assigned duties and responsibilities. If the scope of work involves home modifications, agencies and individuals employed by the agencies must possess any appropriate licenses/certifications required by the state (e.g., Home Improvement Contractor, Construction Supervisor License, Plumbers license, etc.)

			Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific requirements for providers can include provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H.
Architect/Designer Agencies			Any not-for-profit or proprietary organization that becomes qualified through the MRC open procurement process and as such, successfully demonstrates, at a minimum, the following: Providers shall ensure that individual workers employed by the agency have been CORI checked, and are able to perform assigned duties and responsibilities. Staff responsible for architectural drawings must be: Licensed architects, certified designers or draftsmen. Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the

			participant's protected health information. Specific requirements for providers can include provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H.
Architect/Designer			Any self-employed provider that becomes qualified through the MRC open procurement process and as such, successfully demonstrates, at a minimum, the following: Staff responsible for architectural drawings must be: Licensed architects, certified designers or draftsmen. Providers shall submit to a CORI check, and must be able to perform assigned duties and responsibilities. Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific requirements for providers can include provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H.
Home Accessibility Adaptation Provider (Self-Employed)	If the scope of work involves home modifications, agencies and individuals employed by the agencies must possess any appropriate		Any self-employed provider that becomes qualified through the MRC open procurement process and as such, successfully demonstrates, at a minimum, the following:

	licenses/certifications required by the state (e.g., Home Improvement Contractor, Construction Supervisor License, Plumbers license, etc.)		Providers shall submit to a CORI check, and must be able to perform assigned duties and responsibilities. If the scope of work involves home modifications, agencies and individuals employed by the agencies must possess any appropriate licenses/certifications required by the state (e.g., Home Improvement Contractor, Construction Supervisor License, Plumbers license, etc.) Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific requirements for providers can include provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Accessibility Adaptations Agencies	Massachusetts Rehabilitation Commission	Annually, or prior to utilization of service
Architect/Designer Agencies	Massachusetts Rehabilitation Commission	Annually, or prior to utilization of service
Architect/Designer	Massachusetts Rehabilitation Commission	Annually, or prior to utilization of service
Home Accessibility Adaptation Provider (Self-Employed)	Massachusetts Rehabilitation Commission	Annually, or prior to utilization of service

Service Specification

Service Type:

Other Service

Service:

Individual Support and Community Habilitation

☐ Service is included in approved waiver. There is no change in service specifications.

☑ Service is included in approved waiver. The service specifications have been modified.

☐Service is not included in approved waiver.

Service Definition (Scope)**:**

Services and supports in a variety of activities that may be provided regularly or intermittently, but not on a 24-hour basis, and are determined necessary to prevent institutionalization. These services may include locating appropriate housing, the acquisition, retention or improvement of skills related to personal finance, health, shopping, use of community resources, community safety, and other social and adaptive skills to live in the community. Individual support and community habilitation provide supports necessary for the individual to learn and/or retain the skills to establish, live in and maintain a household of their choosing in the community. It may include modeling, training and education in self-determination and self-advocacy to enable the individual to acquire skills to exercise control and responsibility over the services and supports they receive, and to become more independent, integrated, and productive in their communities. This service may be provided remotely via telehealth based on the participant's needs, preferences, and goals as determined during the person-centered planning process and reviewed by the Case Manager during each scheduled reassessment as outlined in Appendix D-2-a. This service may be delivered remotely via telehealth 100% of the time. The methods and minimum frequency with which participants will receive face-to-face contact to ensure health and welfare are described in Appendix D-2-a. ~~These services must be provided in-person, except in limited circumstances as necessary to accomplish specific, time-sensitive tasks.~~

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:	☑	Participant-directed as specified in Appendix E	☑	Provider managed	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative	☐ Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)***:**	☑	Individual. List types:	☑	Agency. List the types of agencies:
		Support Worker		Human Service Agencies
				Health Care Agencies

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Human Service Agencies			Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following

			- Individuals who provide Individual Support and Community Habilitation services must meet requirements for individuals in such roles, including, but not limited to must: have been CORI checked, have a College degree and at least two years comparable community-based human services, life or work experience providing skills training services to individuals with disabilities, or at least five years comparable community-based work experience providing skills training services to individuals with disabilities; can handle emergency situations; can set limits, and communicate effectively with participants, families, other providers and agencies; have ability to meet legal requirements in protecting confidential information; and certification in CPR is required. - Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations. Providers are responsible for ensuring staff are trained on applicable regulations and policies governing waiver service delivery and the principles of participant centered care. Agencies must have established procedures for appraising staff performance and for effectively modifying poor performance where it exists. - Adherence to Continuous QI Practices: Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual participants by providing effective, efficient services. Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required.

			- Availability/Responsiveness: Providers must be able to initiate services with little or no delay in the geographical areas they designate. - Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with applicable laws and policies. - Policies/Procedures: Providers must have policies and procedures that include: Participant Not at Home Policy, Participant Emergency in the Home Policy; and that comply with the applicable standards under 105 CMR 155.000 et seq (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by an Individual Support and Community Habilitation agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable

			regulations, as well with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific requirements for providers can include provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H. Providers licensed, certified and qualified by DDS in accordance with 115 CMR 7.00 (Department of Developmental Services (DDS) regulations for all DDS supports and services provided by public and private providers and those services subject to regulation by the Massachusetts Rehabilitation Commission, which provide social and pre-vocational supports and work training) will be considered to have met these standards.
Support Worker			Other Standard (specify): Individuals who provide Individual Support and Community Habilitation services must have responded satisfactorily to the Waiver provider enrollment process, and must meet requirements for individuals in such roles, including, but not limited to must: have been CORI checked, have a College degree and at least two years comparable community-based, life or work experience providing skills training services to individuals with disabilities, or at least five years comparable community-based work experience providing skills training services to individuals with disabilities; can handle emergency situations; can set limits, and communicate effectively with participants, families, other providers and agencies; have ability to meet legal requirements in protecting confidential information; certification in CPR is required.

			Individuals must be provided with information regarding the applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq(The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). Individuals must attest to having reviewed this information. Policies/Procedures: Providers must have policies that apply to and comply with the applicable standards under 105 CMR 155.000 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a home health agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the

			Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific requirements for providers can include provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H. Providers licensed, certified and qualified by DDS in accordance with 115 CMR 7.00 (Department of Developmental Services (DDS) regulations for all DDS supports and services provided by public and private providers and those services subject to regulation by the Massachusetts Rehabilitation Commission, which provide social and pre-vocational supports and work training) will be considered to have met these standards.
Health Care Agencies			Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following - Individuals who provide Individual Support and Community Habilitation services must meet requirements for individuals in such roles, including, but not limited to must: have been CORI checked, have a College degree and at least two years comparable community-based human services, life or work experience providing skills training services to individuals with disabilities, or at least five years comparable community-based work experience providing skills training services to individuals with disabilities; can handle emergency situations; can set limits, and

			communicate effectively with participants, families, other providers and agencies; have ability to meet legal requirements in protecting confidential information; and certification in CPR is required. - Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations. Providers are responsible for ensuring staff are trained on applicable regulations and policies governing waiver service delivery and the principles of participant centered care. Agencies must have established procedures for appraising staff performance and for effectively modifying poor performance where it exists. - Adherence to Continuous QI Practices: Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual participants by providing effective, efficient services. Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required. - Availability/Responsiveness: Providers must be able to initiate services with little or no delay in the geographical areas they designate. - Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with applicable laws and policies. - Policies/Procedures: Providers must have policies and procedures that include: Participant Not at Home Policy,

			Participant Emergency in the Home Policy; and that comply with the applicable standards under 105 CMR 155.000 et seq (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by an Individual Support and Community Habilitation agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific requirements for providers can include provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H. Providers licensed, certified and qualified by DDS in accordance with

			115 CMR 7.00 (Department of Developmental Services (DDS) regulations for all DDS supports and services provided by public and private providers and those services subject to regulation by the Massachusetts Rehabilitation Commission, which provide social and pre-vocational supports and work training) will be considered to have met these standards.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Human Service Agencies	Administrative Service Organization	Annually
Support Worker	Administrative Service Organization	Annually
Health Care Agencies	Administrative Service Organization	Annually

Service Specification
Service Type:
Other Service
Service:
Occupational Therapy
☐ Service is included in approved waiver. There is no change in service specifications. ☑ Service is included in approved waiver. The service specifications have been modified. ☐Service is not included in approved waiver.
Service Definition (Scope)**:**
Occupational Therapy services, including the performance of a maintenance program beyond the scope of coverage in the State plan, provided by a licensed occupational therapist. Occupational therapy programs are designed to improve the quality of life by recovering competence, preventing further injury or disability, and to improve the individual's ability to perform tasks required for independent functioning, so that the individual can engage in activities of daily living. Services must be considered by the therapist to be necessary for the participant either to improve, develop, correct, rehabilitate, or prevent the worsening of physical, cognitive or sensory functions that have been lost, impaired or reduced as a result of acute or chronic medical conditions, congenital anomalies or injuries; or required to maintain or prevent the worsening of function. Services may also include the training and oversight necessary for the participant, family member or other person, to carry out the maintenance program. The provider qualifications specified in the State plan apply. Occupational Therapy services must be authorized by the Case Manager in the service plan. This service is not subject to the Medical Referral Requirements found at 130 CMR 432.415 (MassHealth Therapist Regulations that describe the medical referral requirements necessary as a prerequisite to MassHealth payment) or the requirements for Prior Authorization found in the following regulations: 130 CMR 432.417 (MassHealth Therapist Regulations that describe the prior authorization process for therapy services) or 130 CMR 410.408 (MassHealth Chronic Disease and Rehabilitation Outpatient Hospital Regulations that describe the prior authorization process for therapy services) or 130 CMR 403.413 (MassHealth Home Health Agency Regulations that describe the prior authorization process for therapy services) or 130 CMR 430.601 (MassHealth Rehabilitation Center Regulations that describe the prior authorization process for therapy

services). This service can not be provided in Adult Day Health or when the participant is receiving other services that include occupational therapy as part of the program.

MassHealth All Provider regulations at 130 CMR 450.140 through 149 detail the ESPDT requirements for MassHealth providers and Appendix W of the MassHealth provider manuals for therapists services lists EPSDT screening schedules.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

These services are subject to the Service Limitations included in 130 CMR 432. 414 (A) and (B) (MassHealth Therapist Regulations that describe the service limitations for therapy treatment per day). No more than one individual treatment and one group therapy session per day may be authorized. Payment will not be made for a treatment claimed for the same date of service as a comprehensive evaluation.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative	☐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)***:**	☑	Individual. List types:	☑	Agency. List the types of agencies:
		Occupational Therapist		Health Care Agencies
				Chronic Disease and Rehabilitation Inpatient and Outpatient Hospital

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Health Care Agencies	The agency must be licensed as a Group Practice in accordance with 130 CMR 432.404 (MassHealth Therapist Regulations that describe the provider eligibility requirements for in-State therapy providers)or as a Rehabilitation Center in accordance with 130 CMR 430.600 (MassHealth Rehabilitation Center Regulations that define provider eligibility requirements and program rules) or as a Home Health		

	Agency in accordance with 130 CMR 403.000 (MassHealth Home Health Agency regulations that define provider eligibility requirements and program rules). Services must be performed by an Occupational Therapist licensed in accordance with 130 CMR 432.000 (MassHealth Therapist Regulations that define provider eligibility requirements and program rules)		
Occupational Therapist	Occupational Therapist licensed in accordance with 130 CMR 432.000 (MassHealth Therapist Regulations that define provider eligibility requirements and program rules)		
Chronic Disease and Rehabilitation Inpatient and Outpatient Hospital	The hospital must be licensed as a Chronic Disease and Rehabilitation Inpatient Hospital in accordance with 130 CMR 435.000 (MassHealth Chronic Disease and Rehabilitation Inpatient Regulations that describe the provider eligibility requirements) or as a Chronic Disease and Rehabilitation		

	Outpatient Hospital in accordance with 130 CMR 410.000 (MassHealth Chronic Disease and Rehabilitation Outpatient Regulations that describe the provider eligibility requirements)		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Health Care Agencies	Administrative Service Organization	~~Annually~~Every 2 years
Occupational Therapist	Administrative Service Organization	~~Annually~~Every 2 years
Chronic Disease and Rehabilitation Inpatient and Outpatient Hospital	Administrative Service Organization	~~Annually~~Every 2 years

Service Specification
Service Type:
Other Service
Service:
Orientation and Mobility Services
☐ Service is included in approved waiver. There is no change in service specifications. ☑ Service is included in approved waiver. The service specifications have been modified. ☐Service is not included in approved waiver.
Service Definition (Scope)**:**
Orientation and Mobility (O&M) services teach an individual with vision impairment or legal blindness how to move or travel safely and independently in ~~his/her~~their home and community and include (a) O&M assessment; (b) training and education provided to Participants; (c) environmental evaluations; (d) caregiver/direct care staff training on sensitivity to blindness/low vision; and (e) information and resources on community living for persons with vision impairment or legal blindness. O&M Services are tailored to the individual's need and may extend beyond residential settings to other community settings as well as public transportation systems.~~.~~
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed		
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative	☐	Legal Guardian

Provider Specifications				
Provider Category(s) *(check one or both)*:	☑	Individual. List types:	☑	Agency. List the types of agencies:
	Certified Orientation and Mobility Specialist (COMS)		Human Service Agencies	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Certified Orientation and Mobility Specialist (COMS)		Individuals providers of Orientation and Mobility Services must have a master's degree in special education with a specialty in orientation and mobility or a bachelor's degree with a certificate in orientation and mobility from an ACVREP (Academy for Certification of Vision Rehabilitation and Education Professionals)-certified university program.	Individuals who provide Orientation and Mobility services must have responded satisfactorily to the Waiver provider enrollment process and must meet requirements for individuals in such roles, including, but not limited to must: have been CORI checked, have life or work experience providing services to individuals with disabilities; can handle emergency situations; can set limits, and communicate effectively with participants, families, other providers and agencies; and have ability to meet legal requirements in protecting confidential information. Individuals providing services must also have: - Knowledge and experience in the evaluation of the needs of an individual with vision impairment or legal blindness, including functional evaluation of the individual in the individual's customary environment. - Knowledge and/or experience in educating caregivers or direct care staff, or other individuals who provide services to or are otherwise substantially involved in the major life functions of individuals with vision impairment or legal blindness, in sensitivity to low vision/blindness. Individuals must be provided with information regarding the applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities)

			and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq(The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). Individuals must attest to having reviewed this information.
Human Service Agencies		Individuals providers and individuals employed by the agency providing Orientation and Mobility Services must have a master's degree in special education with a specialty in orientation and mobility or a bachelor's degree with a certificate in orientation and mobility from an ACVREP-certified university program.	Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following: - Providers shall ensure that individual workers employed by the agency have been CORI checked, and are able to perform assigned duties and responsibilities. Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with applicable laws and policies. Policies/Procedures: Providers must have policies that apply to and comply with the applicable standards under 105 CMR 155.000 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a home health agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations).

			Staff providing services must have: - Master's degree in special education with a specialty in orientation and mobility; or - Bachelor's degree with a certificate in orientation and mobility from an ACVREP-certified university program Individuals providing services must also have: - Knowledge and experience in the evaluation of the needs of an individual with vision impairment or legal blindness, including functional evaluation of the individual in the individual's customary environment. - Knowledge and/or experience in educating caregivers or direct care staff, or other individuals who provide services to or are otherwise substantially involved in the major life functions of individuals with vision impairment or legal blindness, in sensitivity to low vision/blindness.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Certified Orientation and Mobility Specialist (COMS)	Administrative Service Organization	~~Annually~~ Every 2 years
Human Service Agencies	Administrative Service Organization	~~Annually~~ Every 2 years

Service Specification
Service Type:
Other Service
Service:
Peer Support
☐ Service is included in approved waiver. There is no change in service specifications. ☑ Service is included in approved waiver. The service specifications have been modified. ☐Service is not included in approved waiver.
Service Definition (Scope)**:**
Peer Support is designed to provide training, instruction and mentoring to individuals about self-advocacy, participant direction, civic participation, leadership, benefits, and participation in the community. Peer support

may be provided in small groups or peer support may involve one peer providing support to another peer, the waiver participant, to promote and support the waiver participant's ability to participate in self-advocacy. The one to one peer support is instructional; it is not counseling. The service enhances the skills of the individual to function in the community and/or family home. Documentation in the individuals record demonstrates the benefit to the individual. This service may be self-directed.

This service may be provided remotely via telehealth based on the participant's needs, preferences, and goals as determined during the person-centered planning process and reviewed by the Case Manager during each scheduled reassessment as outlined in Appendix D-2-a. This service may be delivered remotely via telehealth 100% of the time. The methods and minimum frequency with which participants will receive face-to-face contact to ensure health and welfare are described in Appendix D-2-a.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Not to exceed 16 hours per week.

Service Delivery Method *(check each that applies)*:	☑	Participant-directed as specified in Appendix E	☑	Provider managed	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative	☐ Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)***:**	☑	Individual. List types:	☑	Agency. List the types of agencies:
	Individual Peer Support Specialist		Peer Support Agencies	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual Peer Support Specialist		~~Relevant competencies and experiences in Peer Support~~	Applicants must have relevant competencies and experiences in Peer Support and ~~must~~ possess appropriate qualifications to serve as staff as evidenced by interview(s), two personal and or professional references and a Criminal Offense Records Inquiry (CORI). The applicant must have the ability to communicate effectively in the language and communication style of the participant to whom they are providing training; Must have experience in providing peer support, self-advocacy, and skills training and independence; Minimum of 18 years of age; Be knowledgeable about what to do in an emergency; Be knowledgeable about how to report abuse and neglect; Must maintain confidentiality and privacy of consumer information; Must be respectful and accept different values, nationalities, races, religions, cultures and standards of living. Specific competencies needed by an individual

			provider to meet the support needs of the participant will be delineated in the Support Plan by the Team. Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific requirements for providers can include provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H. Individuals must be provided with information regarding the applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq(The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). Individuals must attest to having reviewed this information.
Peer Support Agencies	Agency needs to employ individuals who meet all relevant state and federal licensure or certification requirements in their discipline.	If the agency is providing activities where certification is necessary, the applicant will have the necessary certifications.	Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following - Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency

			situations. Providers are responsible for ensuring staff are trained on applicable regulations and policies governing waiver service delivery and the principles of participant centered care. Agencies must have established procedures for appraising staff performance and for effectively modifying poor performance where it exists. - Adherence to Continuous QI Practices: Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual participants by providing effective, efficient services. Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required. - Availability/Responsiveness: Providers must be able to initiate services with little or no delay in the geographical areas they designate. - Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with applicable laws and policies. - Policies/Procedures: Providers must have policies and procedures that include: Participant Emergency in the Home Policy; and that comply with the applicable standards under 105 CMR 155 et seq (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a Peer Support Agency as well as policies that comply with applicable regulations

			of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). - Individuals who provide Peer Support Services must meet requirements for individuals in such roles, including, but not limited to must: have been CORI checked; can handle emergency situations; can set limits, and communicate effectively with participants, other providers and agencies; have ability to meet legal requirements in protecting confidential information. The agency must employ individuals who are self-advocates and supporters and who are able to effectively communicate in the language and communication style of the individual for whom they are providing the training. Staff members providing Peer Support must have experience in providing peer support, self-advocacy, and skills training and independence. Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific

			requirements for providers can include provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual Peer Support Specialist	Administrative Service Organization	Every 2 years
Peer Support Agencies	Administrative Service Organization	Every 2 years

Service Specification
Service Type:
Other Service
Service:
Physical Therapy
☐ Service is included in approved waiver. There is no change in service specifications. ☑ Service is included in approved waiver. The service specifications have been modified. ☐Service is not included in approved waiver.
Service Definition (Scope)**:**
Physical Therapy services, including the performance of a maintenance program beyond the scope of coverage in the State plan, provided by a licensed physical therapist. Services must be considered by the therapist to be necessary for the participant either to improve, develop, correct, rehabilitate, or prevent the worsening of the physical functions that have been lost, impaired or reduced as a result of acute or chronic medical conditions, congenital anomalies or injuries; or required to maintain or prevent the worsening of function. Services may also include the training and oversight necessary for the participant, family member or other person, to carry out the maintenance program. The provider qualifications specified in the State plan apply. Physical Therapy services must be authorized by the Case Manager in the service plan. This service is not subject to the Medical Referral Requirements found at 130 CMR 432.415 (MassHealth Therapist Regulations that describe the medical referral requirements necessary as a prerequisite to MassHealth payment) or the requirements for Prior Authorization found in the following regulations: 130 CMR 432.417 (MassHealth Therapist Regulations that describe the prior authorization process for therapy services)) or 130 CMR 410.408 (MassHealth Chronic Disease and Rehabilitation Outpatient Hospital Regulations that describe the prior authorization process for therapy services) or 130 CMR 403.413 (MassHealth Home Health Agency Regulations that describe the prior authorization process for therapy services) or 130 CMR 430.601 (MassHealth Rehabilitation Center Regulations that describe the prior authorization process for therapy services). This service can not be provided in Adult Day Health or when the participant is receiving other services that include physical therapy as part of the program. MassHealth All Provider regulations at 130 CMR 450.140 through 149 detail the ESPDT requirements for MassHealth providers and the MassHealth provider manuals for therapists services lists EPSDT screening schedules at Appendix W.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

These services are subject to the Service Limitations included in 130 CMR 432. 414 (A) and (B) (MassHealth Therapist Regulations that describe the service limitations for therapy treatment per day). No more than one individual treatment and one group therapy session per day may be authorized. Payment will not be made for a treatment claimed for the same date of service as a comprehensive evaluation..

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative	☐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)***:**	☑	Individual. List types:	☑	Agency. List the types of agencies:
	Physical Therapist		Health Care Agencies	
			Chronic Disease and Rehabilitation Inpatient and Outpatient Hospital	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Physical Therapist	Physical Therapist licensed in accordance with 130 CMR 432.000 (MassHealth Therapist Regulations that define provider eligibility requirements and program rules).		
Health Care Agencies	The agency must be licensed as a Group Practice in accordance with 130 CMR 432.404 (MassHealth Therapist Regulations that describe the provider eligibility requirements for in-State therapy providers)or as a Rehabilitation Center in accordance with 130 CMR 430.600 (MassHealth Rehabilitation Center Regulations that define		

	provider eligibility requirements and program rules)) or as a Home Health Agency in accordance with 130 CMR 403.000 (MassHealth Home Health Agency regulations that define provider eligibility requirements and program rules). Services must be performed by a Physical Therapist licensed in accordance with 130 CMR 432.000 (MassHealth Therapist Regulations that define provider eligibility requirements and program rules).		
Chronic Disease and Rehabilitation Inpatient and Outpatient Hospital	The hospital must be licensed as a Chronic Disease and Rehabilitation Inpatient Hospital in accordance with 130 CMR 435.000 (MassHealth Chronic Disease and Rehabilitation Inpatient Regulations that describe the provider eligibility requirements) or as a Chronic Disease and Rehabilitation Outpatient Hospital in accordance with 130 CMR 410.000 (MassHealth Chronic Disease and Rehabilitation		

	Outpatient Regulations that describe the provider eligibility requirements)		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Physical Therapist	Administrative Service Organization	~~Annually~~Every 2 years
Health Care Agencies	Administrative Service Organization	~~Annually~~Every 2 years
Chronic Disease and Rehabilitation Inpatient and Outpatient Hospital	Administrative Service Organization	~~Annually~~Every 2 years

Service Specification
Service Type:
Other Service
Service:
Residential Family Training
☐ Service is included in approved waiver. There is no change in service specifications. ☑ Service is included in approved waiver. The service specifications have been modified. ☐Service is not included in approved waiver.
Service Definition (Scope)**:**
Residential Family Training is designed to provide training and instruction about the treatment regimes, behavior plans, and the use of specialized equipment that supports the waiver participant to participate in the community. Residential Family Training may also include training in family leadership, support for the family unit to adjust to the changes in the life of the family created by the disability of the participant, support of self-advocacy, and independence for their family member. The service enhances the skill of the family to assist the waiver participant to function in the community and at home when the waiver participant visits his or her family, and supports family members to adjust to the changes in their lives. Documentation in the participant's record demonstrates the benefit to the participant. For the purposes of this service "family" is defined as the persons who provide care to a waiver participant and may include a parent or other relative. Family does not include individuals who are employed to care for the participant other than to support the education and training provided to the family and participant. Residential Family Training may be provided in a small group format or the Family Trainer may provide individual instruction to a specific family based on the needs of the family to understand the specialized needs of the waiver participant. The one to one family training is instructional or psychoeducational rather than counseling. Residential Family Training is not available in provider operated residential habilitation or assisted living sites or in shared living settings unless the waiver participant regularly leaves the site to visit his or her family. This service may be provided remotely via telehealth based on the participant's needs, preferences, and goals as determined during the person-centered planning process and reviewed by the Case Manager during each scheduled reassessment as outlined in Appendix D-2-a. This service may be delivered remotely via telehealth 100% of the time. The methods and minimum frequency with which participants will receive face-to-face contact to ensure health and welfare are described in Appendix D-2-a.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:						
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E		☑	Provider managed	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative	☐	Legal Guardian

Provider Specifications				
Provider Category(s) *(check one or both)*:	☑	Individual. List types:	☑	Agency. List the types of agencies:
	Individual Family Training Provider		Family Training Agencies	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Family Training Agencies	If the agency is providing activities where licensure or certification is necessary, the applicant will have the necessary licensure/certifications. For mental health professionals such as Family Therapists, Rehabilitation Counselors, Social Workers, necessary licensure or certification requirements for those disciplines must be met.		Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following - Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations. Providers are responsible for ensuring staff are trained on applicable regulations and policies governing waiver service delivery and the principles of participant centered care. Agencies must have established procedures for appraising staff performance and for effectively modifying poor performance where it exists. - Adherence to Continuous QI Practices: Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual participants by providing effective, efficient services. Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide

			program and participant quality data and reports, as required. - Availability/Responsiveness: Providers must be able to initiate services with little or no delay in the geographical areas they designate. - Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with applicable laws and policies. - Policies/Procedures: Providers must have policies and procedures that comply with the applicable standards under 105 CMR 155.000 for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a Family Training Agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq. - Individuals who provide Family Training Services must meet requirements for individuals in such roles, including, but not limited to must: have been CORI checked; can handle emergency situations; can set limits, and communicate effectively with participants, families, other providers and agencies; have ability to meet legal requirements in protecting confidential information. The agency must employ individuals who are able to effectively communicate in the language and communication style of the individual or family for whom they are providing the training. Staff members providing

			Family Training must have experience in promoting independence and in family leadership. Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific requirements for providers can include provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H.
Individual Family Training Provider	Individuals who meet all relevant state and federal licensure or certification requirements for their discipline.	Relevant competencies and experiences in Family Training.	Applicants must possess appropriate qualifications to serve as staff as evidenced by interview(s), two personal or professional references, and a Criminal Offense Record Inquiry (CORI). The applicant must have the ability to communicate effectively in the language and communication style of the family to whom they are providing training. The applicant must have experience in providing family leadership, self-advocacy, and skills training in independence. Individuals must be provided with information regarding the applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services

			Program found at 651 CMR 5.00 et seq(The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). Individuals must attest to having reviewed this information. Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific requirements for providers can include provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Family Training Agencies	Administrative Service Organization	~~Annually or prior to utilization of service~~Every 2 years
Individual Family Training Provider	Administrative Service Organization	~~Annually or prior to utilization of service~~Every 2 years

Service Specification
Service Type:
Other Service
Service:
Shared Living – 24 Hour Supports
☐ Service is included in approved waiver. There is no change in service specifications. ☑ Service is included in approved waiver. The service specifications have been modified. ☐Service is not included in approved waiver.
Service Definition (Scope)**:**

Shared Living - 24 Hour Supports is a residential option that matches a participant with a Shared Living caregiver. This arrangement is overseen by a Residential Support Agency. The match between participant and caregiver is the keystone to the success of this model. Shared Living is an individually tailored 24 hour/7 day per week, supportive service.

Shared Living is available to participants who need daily structure and supervision. Shared Living includes supportive services that assist with the acquisition, retention, or improvement of skills related to living in the community. This includes such supports as: adaptive skill development, assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs), adult educational supports, social and leisure skill development, protective oversight and supervision.

Shared Living integrates the participant into the usual activities of the caregivers family life. In addition, there will be opportunities for learning, developing and maintaining skills including in such areas as ADLs, IADLs, social and recreational activities, and personal enrichment. The Residential Support Agency provides regular and ongoing oversight and supervision of the caregiver.

The caregiver lives with the participant at the residence of the caregiver or the participant. Shared Living agencies recruit caregivers, assess their abilities, coordinate placement of participant or caregiver, train and provide guidance, supervision and oversight for caregivers and provide oversight of participants living situations. The caregiver may not be a legally responsible family member.

Duplicative waiver and state plan services are not available to participants receiving Shared Living services. Participants may receive only one residential support service at a time.

Shared Living services are not available to individuals who live with their immediate family unless the family member is not legally responsible for the individual and is employed as the caregiver, or the immediate family member (grandparent, parent, sibling or spouse) is also eligible for shared living and had received prior authorization, as applicable. Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment is specified in Appendix I-5.
Shared Living may be provided to no more than two participants in a home.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative	☐ Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Residential Support Agencies

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Residential Support Agencies	115 CMR 7.00 (Department of Developmental Services Standards for	Residential Support Agency Provider employees must have a High School	Residential Support Agency Provider employees must possess appropriate qualifications as evidenced by interview(s), two personal or

	all Services and Supports) and 115 CMR 8.00 (Department of Developmental Services Certification, Licensing and Enforcement Regulations) or 104 CMR Chapter 28 (Department of Mental Health regulations governing Licensing and Operational Standards for Community Programs).	diploma, GED or relevant equivalencies or competencies.	professional references and a Criminal Offender Records Inquiry (CORI), be age 18 years or older, be knowledgeable about what to do in an emergency; be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, maintain confidentiality and privacy of the consumer, respect and accept different values, nationalities, races, religions, cultures and standards of living. Policies/Procedures: Providers must have policies that apply to and comply with the applicable standards under 105 CMR 155.000 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a home health agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations).

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Residential Support Agencies	Department of Developmental Services (DDS) Office of Quality Enhancement, Survey and Certification staff.	Every 2 years

Service Specification
Service Type:
Other Service
Service:
Skilled Nursing
☐ Service is included in approved waiver. There is no change in service specifications. ☑ Service is included in approved waiver. The service specifications have been modified. ☐Service is not included in approved waiver.
Service Definition (Scope)**:**
Services listed in the service plan that are within the scope of the State's Nurse Practice Act and are provided by a Registered Nurse or a Licensed Practical Nurse with a valid Massachusetts license. Skilled nursing services under the waiver differ in nature, scope, supervision arrangements, or provider type (including provider training and qualifications) from skilled nursing services in the State plan. The differences from the State plan are as follows: 1) Agencies that provide Skilled Nursing services under the waiver do not need to meet the requirements for participation in Medicare, as provided in 42 CFR §489.28. MassHealth All Provider regulations at 130 CMR 450.140 through 149 detail the ESPDT requirements for MassHealth providers and the MassHealth provider manual for nursing services lists EPSDT screening schedules at Appendix W.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service is limited to one Skilled Nursing visit per week. The State may grant exceptions to the limit on a temporary basis to facilitate transitions to a community setting, to ensure that an individual at risk for medical facility admission is able to remain in the community, or to otherwise stabilize a participants medical condition

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative	☐ Legal Guardian

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Homemaker/Personal Care Agencies
				Home Health Agencies

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Homemaker/Personal Care Agencies	Skilled Nursing services must be performed by a Registered Nurse or a Licensed Practical Nurse with a valid Massachusetts license.		Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following: - Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their

			job duties, including handling emergency situations. Providers are responsible for ensuring staff are trained on applicable regulations and policies governing waiver service delivery and the principles of participant centered care. Agencies must have established procedures for appraising staff performance and for effectively modifying poor performance where it exists. - Adherence to Continuous QI Practices: Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual participants by providing effective, efficient services. Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required. - Availability/Responsiveness: Providers must be able to initiate services with little or no delay in the geographical areas they designate. - Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with applicable laws and policies. - Policies/Procedures: Providers must have policies and procedures that include: Participant Not at Home Policy, Participant Emergency in the Home Policy; and that comply with the applicable standards under 105 CMR 155 et seq (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a

			Home Health Agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). - Individuals who provide Skilled Nursing Services must meet requirements for individuals in such roles, including, but not limited to must: have been CORI checked; experience providing services to individuals with disabilities; can handle emergency situations; can set limits, and communicate effectively with participants, families, other providers and agencies; have ability to meet legal requirements in protecting confidential information.
Home Health Agencies	Skilled Nursing services must be performed by a Registered Nurse or a Licensed Practical Nurse with a valid Massachusetts license.		Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following: - Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations. Providers are responsible for ensuring staff are trained on applicable regulations and policies governing waiver service delivery and the principles of participant centered care. Agencies must have established procedures for appraising staff performance and for effectively modifying poor performance where it exists.

			- Adherence to Continuous QI Practices: Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual participants by providing effective, efficient services. Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required. - Availability/Responsiveness: Providers must be able to initiate services with little or no delay in the geographical areas they designate. - Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with applicable laws and policies. - Policies/Procedures: Providers must have policies and procedures that include: Participant Not at Home Policy, Participant Emergency in the Home Policy; and that comply with the applicable standards under 105 CMR 155 et seq (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a Home Health Agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651

			CMR 5.00 et seq. (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). - Individuals who provide Skilled Nursing Services must meet requirements for individuals in such roles, including, but not limited to must: have been CORI checked; experience providing services to individuals with disabilities; can handle emergency situations; can set limits, and communicate effectively with participants, families, other providers and agencies; have ability to meet legal requirements in protecting confidential information.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Homemaker/Personal Care Agencies	Administrative Service Organization	~~Annually~~Every 2 years
Home Health Agencies	Administrative Service Organization	~~Annually~~Every 2 years

Service Specification
Service Type:
Other Service
Service:
Specialized Medical Equipment
☐Service is included in approved waiver. There is no change in service specifications. ☑ Service is included in approved waiver. The service specifications have been modified. ☐Service is not included in approved waiver.
Service Definition (Scope)**:**
Specialized Medical Equipment includes: (a) devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment not available under the State plan that is necessary to address participant functional limitations; and, (e) necessary medical supplies not available under the State plan. In addition to the acquisition of the Specialized Medical Equipment itself this service may include: - Evaluations necessary for the selection, design, fitting or customizing of the equipment needs of a participant - Customization, adaptations, fitting, set-up, maintenance or repairs to the equipment or devices

- Temporary replacement of equipment
- Training or technical assistance for the participant, or, where appropriate, the family members, guardians, or other caregivers of the participant on the use and maintenance of the equipment or devices.

Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation. This service does not include vehicle modifications, ~~or~~ home accessibility adaptations, or any devices provided through the Assistive Technology service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative	☐ Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	☑	Individual. List types:	☑	Agency. List the types of agencies:
	Individual Assistive Technology Provider		Medical Equipment Suppliers	
			Pharmacies	
			Assistive Technology Agencies	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Medical Equipment Suppliers			Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following: - Providers shall ensure that individual workers employed by the agency have been CORI checked, ~~-~~and are able to perform assigned duties and responsibilities. - Providers of specialized medical equipment and supplies must ensure that all devices and supplies have been examined and/or tested by Underwriters Laboratory (or other appropriate organization), and comply with FCC regulations, as appropriate.
Individual Assistive Technology Provider			Individuals who provide Assistive Technology services must have

			responded satisfactorily to the Waiver provider enrollment process and must meet requirements for individuals in such roles, including, but not limited to must: have been CORI checked and communicate effectively with participants, families, other providers and agencies; have ability to meet legal requirements in protecting confidential information. Individuals providing services must have: - Bachelor's degree in a related technological field and at least one year of demonstrated experience providing adaptive technological assessment or training; or - A bachelor's degree in a related health or human service field with at least two years of demonstrated experience providing adaptive technological assessment or training; or - Three years of demonstrated experience providing adaptive technological assessment or training. Individuals providing services must also have: - Knowledge and experience in the evaluation of the needs of an individual with a disability, including functional evaluation of the individual in the individual's customary environment. - Knowledge and experience in the purchasing, or otherwise providing for the acquisition of assistive technology devices by individuals with disabilities. - Knowledge and/or experience in selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices. - Knowledge and/or experience in coordinating and using other therapies, interventions, or services with assistive technology devices. - Knowledge and/or experience in training or providing technical assistance

			for an individual with disabilities, or, when appropriate, the family of an individual with disabilities or others providing support to the individual. - Knowledge and/or experience in training and/or providing technical assistance for professionals or other individuals who~~m~~ provide services to or are otherwise substantially involved in the major life functions of individuals with disabilities.
Pharmacies			Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following: - Providers shall ensure that individual workers employed by the agency have been CORI checked~~,~~ and are able to perform assigned duties and responsibilities. - Providers of specialized medical equipment and supplies must ensure that all devices and supplies have been examined and/or tested by Underwriters Laboratory (or other appropriate organization), and comply with FCC regulations, as appropriate.
Assistive Technology Agencies			Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following: - Providers shall ensure that individual workers employed by the agency have been CORI checked~~,~~ and are able to perform assigned duties and responsibilities. - Providers of specialized medical equipment and supplies must ensure that all devices and supplies have been examined and/or tested by Underwriters Laboratory (or other appropriate organization), and comply with FCC regulations, as appropriate.

			Staff providing services must have: - Bachelor's degree in a related technological field and at least one year of demonstrated experience providing adaptive technological assessment or training; or - A bachelor's degree in a related health or human service field with at least two years of demonstrated experience providing adaptive technological assessment or training; or - Three years of demonstrated experience providing adaptive technological assessment or training. Individuals providing services must also have: - Knowledge and experience in the evaluation of the needs of an individual with a disability, including functional evaluation of the individual in the individual's customary environment. - Knowledge and experience in the purchasing, or otherwise providing for the acquisition of assistive technology devices by individuals with disabilities. - Knowledge and/or experience in selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices. - Knowledge and/or experience in coordinating and using other therapies, interventions, or services with assistive technology devices. - Knowledge and/or experience in training or providing technical assistance for an individual with disabilities, or, when appropriate, the family of an individual with disabilities or others providing support to the individual. - Knowledge and/or experience in training and/or providing technical assistance for professionals or other individuals who~~m~~ provide services to or are otherwise substantially involved in the major life functions of individuals with disabilities.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Medical Equipment Suppliers	Administrative Service Organization	Every 2 years
Individual Assistive Technology Provider	Administrative Service Organization	Every 2 years
Pharmacies	Administrative Service Organization	Every 2 years
Assistive Technology Agencies	Administrative Service Organization	Every 2 years

Service Specification
Service Type:
Other Service
Service:
Speech Therapy
☐ Service is included in approved waiver. There is no change in service specifications. ☑ Service is included in approved waiver. The service specifications have been modified. ☐Service is not included in approved waiver.
Service Definition (Scope)**:**
Speech Therapy services, including the performance of a maintenance program beyond the scope of coverage in the State plan, provided by a licensed speech therapist. Services must be considered by the therapist to be necessary for the participant either to improve, develop, correct, rehabilitate, or prevent the worsening of speech/language communication and swallowing disorders that have been lost, impaired or reduced as a result of acute or chronic medical conditions, congenital anomalies or injuries; or required to maintain or prevent the worsening of function. Speech therapy services may be used to address speech and language disorders that affect articulation of speech, sounds, fluency, voice, swallowing (regardless of presence of a communication disability) and those that impair comprehension, spoken, written or other symbol systems for communication. Services may also include the training and oversight necessary for the participant, family member or other person, to carry out the maintenance program. The provider qualifications specified in the State plan apply. Speech Therapy services must be authorized by the Case Manager in the service plan. This service is not subject to the Medical Referral Requirements found at 130 CMR 413.419 (MassHealth Speech and Hearing Center Regulations that describe the medical referral requirements necessary as a prerequisite for MassHealth payment)or the requirements for Prior Authorization found in the following regulations: 130 CMR 413.408 (MassHealth Speech and Hearing Center Regulations that describes the prior authorization process for therapy services) or 130 CMR 432.417 (MassHealth Therapist Regulations that describe the prior authorization process for therapy services) or 130 CMR 410.408 (MassHealth Chronic Disease and Rehabilitation Outpatient Hospital Regulations that describe the prior authorization process for therapy services) or 130 CMR 403.413 (MassHealth Home Health Agency Regulations that describe the prior authorization process for therapy services) or 130 CMR 430.601 (MassHealth Rehabilitation Center Regulations that describe the prior authorization process for therapy services). This service can not be provided in Adult Day Health or when the participant is receiving other services that include speech therapy as part of the program.

This service may be provided remotely via telehealth based on the participant's needs, preferences, and goals as determined during the person-centered planning process and reviewed by the Case Manager during each scheduled reassessment as outlined in Appendix D-2-a. This service may be delivered remotely via telehealth 100% of the time. The methods and minimum frequency with which participants will receive face-to-face contact to ensure health and welfare are described in Appendix D-2-a.

MassHealth All Provider regulations at 130 CMR 450.140 through 149 detail the ESPDT requirements for MassHealth providers and the MassHealth provider manuals for therapists services lists EPSDT screening schedules at Appendix W.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

These services are subject to the Service Limitations included in 130 CMR 413. 418 (A) and (B)(MassHealth Speech and Hearing Center Regulations that describe the prior authorization process for therapy services). No more than one individual treatment and one group therapy session per day may be authorized. Payment will not be made for a treatment claimed for the same date of service as a comprehensive evaluation.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative	☐ Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)***:**	☑	Individual. List types:	☑	Agency. List the types of agencies:
		Speech/Language Therapy (Speech/Language Pathologist)		Chronic Disease and Rehabilitation Inpatient and Outpatient Hospital
				Health Care Agencies

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Chronic Disease and Rehabilitation Inpatient and Outpatient Hospital	The hospital must be licensed as a Chronic Disease and Rehabilitation Inpatient Hospital in accordance with 130 CMR 435.000 (MassHealth Chronic Disease and Rehabilitation Inpatient Regulations that describe the provider eligibility requirements) or as a Chronic Disease and Rehabilitation Outpatient Hospital in accordance with 130 CMR 410.000 (MassHealth		Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific requirements for providers can include provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H.

	Chronic Disease and Rehabilitation Outpatient Regulations that describe the provider eligibility requirements)		
Health Care Agencies	The agency must be licensed as a Speech and Hearing Center Group Practice in accordance with 130 CMR 413.404 (MassHealth Speech and Hearing Center Regulations that describe the provider eligibility requirements) or as a Group Practice in accordance with 130 CMR 432.404 (MassHealth Therapist Regulations that describe the provider eligibility requirements for therapy providers) or as a Rehabilitation Center in accordance with 130 CMR 430.600 (MassHealth Rehabilitation Center Regulations that define provider eligibility requirements and program rules) or as a Home Health Agency in accordance with 130 CMR 403.000 (MassHealth Home Health Agency regulations that define provider		Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific requirements for providers can include provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H.

	eligibility requirements and program rules). Services must be performed by a Speech/Language Therapist licensed in accordance with 130 CMR 432.000 (MassHealth Therapist Regulations that define provider eligibility requirements and program rules).		
Speech/Language Therapy (Speech/Language Pathologist)	Speech/Language Therapist licensed in accordance with 130 CMR 432.000 (MassHealth Therapist Regulations that define provider eligibility requirements and program rules).		Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific requirements for providers can include provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Chronic Disease and Rehabilitation Inpatient and Outpatient Hospital	Administrative Service Organization	~~Annually~~Every 2 years
Health Care Agencies	Administrative Service Organization	~~Annually~~Every 2 years
Speech/Language Therapy (Speech/Language Pathologist)	Administrative Service Organization	~~Annually~~Every 2 years

Service Specification
Service Type:

Other Service

Service:

Transitional Assistance Services

☐ Service is included in approved waiver. There is no change in service specifications.

☑ Service is included in approved waiver. The service specifications have been modified.

☐Service is not included in approved waiver.

Service Definition (Scope)**:**

Transitional Assistance services are non-recurring personal household set-up expenses for individuals who are transitioning from a nursing facility or hospital or another provider-operated living arrangement to a community living arrangement where the person is directly responsible for his or her own set-up expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include: (a) assistance with housing search and housing application processes, (b) security deposits that are required to obtain a lease on an apartment or home; (c) assistance arranging for and supporting the details of the move; (d) essential personal household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (e) set-up fees or deposits for utility or service access, including telephone service, electricity, heating and water; (f) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; (g) moving expenses; (h) necessary home accessibility adaptations; and, (i) activities to assess need, arrange for and procure needed resources related to personal household expenses, specialized medical equipment, or community services. Transitional Assistance services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources. Transitional Assistance services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

This service may be provided remotely via telehealth based on the participant's needs, preferences, and goals as determined during the person-centered planning process and reviewed by the Case Manager during each scheduled reassessment as outlined in Appendix D-2-a. This service may be delivered remotely via telehealth 100% of the time. The methods and minimum frequency with which participants will receive face-to-face contact to ensure health and welfare are described in Appendix D-2-a.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Transitional Assistance ~~–RS~~ services include only those non-recurring set up expenses incurred during the 180 days prior to discharge from a nursing facility or hospital or another provider-operated living arrangement to a community living arrangement or during the period following such a transition during which the participant is establishing his or her living arrangement. Home accessibility adaptations are limited to those which are initiated during the 180 days prior to discharge.

Transitional Assistance ~~–RS~~ services may not be used to pay for furnishing living arrangements that are owned or leased by a waiver provider where the provision of these items and services are inherent to the service they are already providing.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative	☐ Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Certified Business

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Certified Business		Certified Business	Will meet applicable State regulations and industry standards for type of goods/services provided. Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific requirements for providers can include provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Certified Business	Massachusetts Rehabilitation Commission	Annually or prior to utilization of service

Service Specification
Service Type:
Other Service
Service:
Transportation
☑ Service is included in approved waiver. There is no change in service specifications. ☐ Service is included in approved waiver. The service specifications have been modified. ☐Service is not included in approved waiver.
Service Definition (Scope)**:**
Service offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the service plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, defined at 42

CFR §440.170(a), and does not replace them. Transportation services under the waiver are offered in accordance with the participant's service plan. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative	☐ Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Transportation Provider Agencies

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Transportation Provider Agencies			Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following: - Driver and Vehicle Requirements: Verification of valid driver's license, liability insurance, written certification of vehicle maintenance, age of vehicles; passenger capacity of vehicles; RMV inspection; seat belts; list of safety equipment; air conditioning and heating; first aid kits; snow tires in winter; and two-way communication. - Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations. Established procedures for appraising staff performance and for effectively modifying poor performance where it exists. - Adherence to Continuous QI Practices: Providers must have established strategies to prevent, detect, and correct problems in the quality of services

			provided and to achieve service plan goals with individual participants by providing effective, efficient services. Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required. - Availability/Responsiveness: Providers must be able to initiate services with little or no delay in the geographical areas they designate. - Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with applicable laws and policies. - Policies/Procedures: Providers must have policies and procedures that include: Participant Not at Home Policy, Participant Emergency in the Home Policy; and that comply with the applicable standards under 105 CMR 155 et seq (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a transportation agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations).

			Providers must ensure that staff who transport must: have been CORI checked; experience providing services to individuals with disabilities; can handle emergency situations; and communicate effectively with participants, families, other providers and agencies. Providers that are certified by the EOHHS Human Services Transportation brokerage service are considered to have met the requirements above.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Transportation Provider Agencies	Administrative Service Organization	Annually

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

○	**Not applicable** – Case management is not furnished as a distinct activity to waiver participants.
☑	**Applicable** – Case management is furnished as a distinct activity to waiver participants. Check each that applies:

☐	As a waiver service defined in Appendix C-3 *Do not complete item C-1-c.*
☐	As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*
☐	As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*
☑	As an administrative activity. *Complete item C-1-c.*
☐	As a primary care case management system service under a concurrent managed care authority. *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

State agency staff from Department of Developmental Services (DDS)

Appendix C-2: General Service Specifications

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services *(select one)*:

☑	**Yes**. Criminal history and/or background investigations are required. Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):
	In accordance with M.G.L. chapter 6, section 172C, the Commonwealth of Massachusetts requires entities to obtain Criminal Offender Record Information (CORI) checks on individuals before they can volunteer, be employed or be referred for employment in an entity providing services to elderly or disabled persons in their homes or in a community setting. CORI checks are statewide in scope. Compliance is verified as part of the credentialing and/or licensure process. DDS, MRC, the FMS and the ASO are responsible for reviewing compliance as part of the Waiver service provider enrollment process and ongoing provider review processes.
○	**No**. Criminal history and/or background investigations are not required.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry *(select one)*:

☑	**Yes**. The state maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):
	105 CMR 155 et seq (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) establishes a registry to be maintained by the Massachusetts Department of Public Health which contains: 1) the names of individuals who are certified as nurse aides, and (2) sanctions, findings and adjudicated findings of abuse, neglect, and mistreatment of patients or residents and misappropriation of patient or resident property imposed upon or made against nurse aides, home health aides and homemakers for the abuse, neglect, mistreatment of patients or residents or misappropriation of patient or resident property. Each employer is responsible for screening potential employees against the abuse registry. Screening must be conducted for any position requiring homemaker, personal care, home health aide or nurse aide training. Provider agency compliance with 105 CMR 155 et seq (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) is verified as part of the credentialing process.
○	**No**. The state does not conduct abuse registry screening.

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

☑	**No**. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.
○	**Yes**. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services. Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

○	**The state does not make payment to relatives/legal guardians for furnishing waiver services.**
○	**The state makes payment to relatives/legal guardians under *specific circumstances* and only when the relative/guardian is qualified to furnish services**. Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*
☑	**Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.** Specify the controls that are employed to ensure that payments are made only for services rendered.
	Relatives, but not legal guardians, are permitted to provide waiver services. A relative may not be a family member (defined as a spouse or any legally responsible relative), and must meet all provider qualifications for the service being provided. Under these circumstances, relatives may provide any of the services included in this waiver without limit. Provider agencies are responsible for ensuring that every employee meets service-specific qualifications and must demonstrate compliance with this during on-site audits. All other requirements under this waiver apply, e.g., services must be provided in accordance with an approved plan of care.
○	Other policy. *Specify*:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Any willing and qualified provider has the opportunity to enroll as a provider of waiver services. Providers of waiver services available under this waiver will meet qualifications as specified in C-1. All waiver service providers, with the exception of Residential Habilitation, Shared Living - 24 Hour Supports, Home Accessibility Adaptations and Transitional Assistance Services will enroll as MassHealth providers and the Administrative Service Organization will ensure they meet the applicable qualifications. Providers of Residential Habilitation and Shared Living - 24 Hour Supports will be qualified and licensed/certified by DDS. Providers of Home Accessibility Adaptations and Transitional Assistance Services will be qualified by MRC.

Providers can access information through the MassHealth provider enrollment and credentialing website, which provides ready access to information regarding requirements and procedures to qualify as a waiver provider. Service providers can apply to enroll at any time.

MRC has issued open procurements to solicit all willing and qualified providers of Home Accessibility Adaptations and Transitional Assistance Services. DDS will contract with all willing and qualified providers of Residential Habilitation and Shared Living-24 Hour Supports. These procurements are posted on the Commonwealth's online procurement access and solicitation system.

Quality Improvement: Qualified Providers

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. Sub-Assurance: The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.

i. Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section

provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	% of agency providers licensed by DDS that have corrected identified deficiencies. (Number of providers that have corrected deficiencies/ Number of providers with identified deficiencies)

Data Source *(Select one) (Several options are listed in the on-line application): Provider performance monitoring*

If 'Other' is selected, specify:

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	
		☑ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☑ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☐ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other*

	Specify:

Performance Measure:	% of licensed or certified providers credentialed by the Provider Network Administration/Massachusetts Rehabilitation Commission that have corrected identified findings. (Number of licensed or certified providers that have corrected identified findings/ Total number of licensed or certified providers that have findings)

Data Source *(Select one) (Several options are listed in the on-line application): Provider performance monitoring*

If 'Other' is selected, specify:

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☑ *Other Specify:*	☑ *Annually*	
	Administrative Services Organization	☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☑ *Annually*
	☐ *Continuously and Ongoing*

	☐ *Other Specify:*

Performance Measure:	% of licensed/certified providers credentialed by the Provider Network Administration/Massachusetts Rehabilitation Commission who continue to meet applicable licensure/certification requirements. (Number of licensed/certified providers who continue to meet applicable licensure requirements/Number of licensed/certified providers who are required to have applicable state licensure or certification)

Data Source *(Select one) (Several options are listed in the on-line application):* **Provider performance monitoring**

If 'Other' is selected, specify:

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☑ *Other Specify:*	☑ *Annually*	
	Administrative Service Organization	☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other*	☑ *Annually*

Specify:	
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	% of licensed or certified providers credentialed by the Provider Network Administration/Massachusetts Rehabilitation Commission that initially meet applicable licensure or certification requirements. (Number of licensed or certified providers with appropriate credentials/ Number of licensed or certified providers)

Data Source *(Select one) (Several options are listed in the on-line application):* **Provider performance monitoring**

If 'Other' is selected, specify:

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☑ *Other Specify:*	☑ *Annually*	
	Administrative Services Organization	☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*

☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☑ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	% of new agency providers, licensed by DDS, that received an initial license to provide supports. (Number of new agency providers that received a license to operate within 6 months of initial review/ Number of new agency providers that were selected to provide support)

Data Source *(Select one) (Several options are listed in the on-line application):* **Provider performance monitoring**

If 'Other' is selected, specify:

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	
		☑ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*

☐ *Operating Agency*	☑ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☐ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	% of providers licensed by DDS that continue to meet applicable licensure or certification standards. (Number of providers that continue to meet applicable licensure or certification standards/ Number of providers subject to licensure/certification)
Data Source *(Select one) (Several options are listed in the on-line application):* **Provider performance monitoring**	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	
		☑ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*

☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☑ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☐ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

b. Sub-Assurance: The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

i. Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	% of providers who are not subject to licensure or certification who continue to meet qualifications to provide services. (Number of providers who continue to meet requirements/ Total number of providers not subject to licensure or certification)
Data Source *(Select one) (Several options are listed in the on-line application):* **Provider performance monitoring**	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*

	☐ *Sub-State Entity*	☐ *Quarterly*		☐ *Representative Sample; Confidence Interval =*
	☑ *Other Specify:*	☑ *Annually*		
	Administrative Services Organization	☐ *Continuously and Ongoing*		☐ *Stratified: Describe Group:*
		☐ *Other Specify:*		
				☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☑ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	% of providers not subject to licensure or certification who are offering services who initially meet requirements to provide supports. (Number of providers not subject to licensure or certification who initially meet the qualification requirements to provide services/ Number of providers)
Data Source *(Select one) (Several options are listed in the on-line application):* **Provider performance monitoring**	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*

	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☑ *Other Specify:*	☑ *Annually*	
	Administrative Services Organization	☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☑ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	% of providers who are not subject to licensure or certification who have corrected identified findings. (Number of providers who are not subject to licensure or certification that have corrected all identified findings/ Total number of providers who are not subject to licensure or certification that have findings)
Data Source *(Select one) (Several options are listed in the on-line application):* **Provider performance monitoring**	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*

	☑ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☑ *Other Specify:*	☑ *Annually*	
	Administrative Services Organization	☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☑ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

c. Sub-Assurance: The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

i. Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	% of providers that are not subject to DDS licensure and/or certification that have been trained and are current in all required trainings. (Number of providers (not subject to DDS licensure and/or certification) that have been trained/ Number of providers reviewed)
Data Source *(Select one) (Several options are listed in the on-line application):* **Provider performance monitoring**	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☑ *Other Specify:*	☑ *Annually*	
	Administrative Service Organization	☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☑ *Annually*

	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	% of DDS licensed/certified providers that have staff trained and current in required trainings including medication administration, CPR, first aid, restraint utilization and abuse/neglect reporting. (Number of DDS licensed/certified providers that have staff trained/ Number of DDS licensed/certified providers reviewed through survey and certification)
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	
		☑ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☑ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other*	☐ *Annually*

Specify:	
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

ii *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

The Department of Developmental Services (DDS) and MassHealth are responsible for ensuring effective oversight of the waiver program, including administrative and operational functions performed by the Level of Care entity and the Administrative Service Organization. As problems are discovered with the management of the waiver program, the Administrative Services Organization, or waiver service providers, MassHealth/DDS will ensure that a corrective action plan is created, approved, and implemented within appropriate timelines. Timelines for remediation will be dependent on the nature and severity of the issue to be addressed. Further, MassHealth is responsible for identifying and analyzing trends related to the operation of the waiver and determining strategies to address quality- related issues.

ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	***Responsible Party*** *(check each that applies)*	***Frequency of data aggregation and analysis:*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*
	☐ *Operating Agency*	☐ *Monthly*
	☐ *Sub-State Entity*	☐ *Quarterly*
	☐ *Other: Specify:*	☑ *Annually*

		☐ *Continuously and Ongoing*
		☐ *Other: Specify:*

c. Timelines

When the state does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

☑	**No**
○	**Yes** Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C-4: Additional Limits on Amount of Waiver Services

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services *(check each that applies)*.

○	**Not applicable – The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.**
☑	**Applicable – The state imposes additional limits on the amount of waiver services.**

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; and, (f) how participants are notified of the amount of the limit.

☐	**Limit(s) on Set(s) of Services**. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver. *Furnish the information specified above*.
☐	**Prospective Individual Budget Amount**. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. *Furnish the information specified above*.
☐	**Budget Limits by Level of Support**. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services. *Furnish the information specified above*.
☑	**Other Type of Limit.** The state employs another type of limit. *Describe the limit and furnish the information specified above.*
	Waiver participants may not receive per diem Day Services on the same day that they receive Community Based Day Supports (CBDS), or Supported Employment or Pre-vocational Services. Waiver participants may receive partial per diem Day Services on the same day that they receive Community Based Day Supports (CBDS), or Supported Employment or Pre-vocational Services. Day Services, CBDS, Supported Employment and Pre-vocational Services, in combination, are limited to no more than 156 hours per month, with each ~~day~~ per diem of Day Services considered to be 6 hours, and each partial per diem considered to be 3 hours. CBDS, pre-vocational services, and supported employment may be used in combination on the same day. CBDS, Pre-vocational services, supported employment services, and Day Services may be used in combination as specified in a participant's Plan of Care up to the aggregate limit of 156 hours per month, with the limitations noted

	above.~~; however, Day Services may not be used in combination with these other services on any given day.~~ This limit is based on historical experience providing Day Services in this waiver. This limit may be adjusted based on review of future utilization patterns. The State may grant individualized exceptions to the limit on a 30-day basis in order to maintain a participant's tenure in the community, to facilitate transitions to a community setting, or to otherwise facilitate the participant's successful engagement in community-based waiver services. Participants are notified of these limits during the service plan development process. Participants in need of additional support services will be referred to alternative waiver or state plan services to meet their needs.

Appendix C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

The Massachusetts Executive Office of Health and Human Services (EOHHS), the single State Medicaid Agency, convened an interagency workgroup to address how best to comply with the requirements of the federal Home and Community Based (HCB) settings requirements at 42 CFR 441.301 (c)(4)-(5). The Department of Developmental Services (DDS), an agency within EOHHS that has primary responsibility for day-to-day operation of the MFP-RS waiver, was a member of the workgroup.

The DDS review and assessment process included: a thorough review of regulations, policies and procedures, waiver service definitions, provider qualifications and quality management and oversight systems to determine whether the systemic infrastructure was consistent with the principles of community integration; development of an assessment tool that borrowed substantially from the exploratory questions that CMS published; and review of existing residential and non-residential settings to determine if those settings met standards consistent with the federal HCB settings requirements.

Based upon initial and ongoing DDS review and assessment, all the 24 hour residential settings serving participants in the MFP-RS and the ABI-RH waivers were determined to be in compliance with federal HCB settings requirements with the exception of consistently having legally enforceable leases, which have now been put into place.

DDS ~~will~~ monitors providers' and settings' compliance with the HCBS settings rule through established quality management mechanisms. These include the licensure and certification process, Area Office oversight, the Service Coordinator Supervisor Tool, incident reporting, human rights protections, site feasibility review, the statewide Quality Council, and National Core Indicator surveys. While providers are expected to have robust internal quality management and improvement processes, DDS staff—including licensure and certification surveyors, program monitors, and Area and Regional staff—conduct all reviews and monitoring. Should any of the ongoing monitoring indicate a need for a substantive change in the STP, DDS along with MassHealth will revise the STP, complete public input activities, and resubmit the STP for CMS approval.

Assisted Living Residences (ALRs) are certified by the Executive Office of Elder Affairs (EOEA), an agency within EOHHS, in accordance with 651 CMR 12.00 (EOEA regulations

describing the certification procedures and standards for Assisted Living Residences in Massachusetts), and must comply with the applicable requirements of the Community Rule (42 CFR 441.301(c)(4)). Oversight and monitoring of ALRs is conducted by EOEA as part of the certification process, with review by the ~~PNA~~ ASO entity for ALRs that enroll as waiver providers for Assisted Living Services.

Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	Plan of Care (POC)

a. **Responsibility for Service Plan Development**. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(check each that applies)*:

☐	**Registered nurse, licensed to practice in the state**
☐	**Licensed practical or vocational nurse, acting within the scope of practice under state law**
☐	**Licensed physician (M.D. or D.O)**
☐	**Case Manager** (qualifications specified in Appendix C-1/C-3)
☑	**Case Manager** (qualifications not specified in Appendix C-1/C-3). *Specify qualifications*:
	Case Managers must have a Bachelor's degree in social work, human services, nursing, psychology, sociology or a related field. Candidates with a Bachelor's degree in another discipline must demonstrate experience or strong interest in the field of human services via previous employment, internships, volunteer activities and/or additional studies. Three years of experience working with elders and/or individuals with disabilities in community settings providing direct case management including performing assessments may be substituted for the degree requirement.
☐	**Social Worker** *Specify qualifications:*
☐	**Other** *Specify the individuals and their qualifications:*

b. Service Plan Development Safeguards.

Select one:

☑	**Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
○	**Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.** The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify*:

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The service plan development process is driven by the individual and facilitated by Case Managers utilizing a person-centered planning approach and assessment tool designed to promote enabling the individual to live as independently and self-sufficiently as possible and as desired. Case Managers must be aware of and know how to access a wide variety of community-based services, as well as work collaboratively with other agencies or individuals, as appropriate, in order to explain to participants the full array of waiver, Title XIX State Plan, and other services available to meet the participant's needs. Case Managers will work with the participant to identify who the participant wishes to include in the service planning process and the development of the Plan of Care (POC).

The Case Manager supports a participant through the entire service planning process. The Service Planning Process described in Appendix D produces the Waiver Plan of Care (POC) document.

The Case Manager has a discussion with the participant or guardian prior to the service plan meeting. At the participant's discretion, other team members such as family and staff also participate in this discussion. The discussion includes:

- An explanation of the service planning process to the participant/guardian and designated representative such as a family member.
- Identification of the person's goals, strengths, and preferences regarding services and Care Plan Team members.
- A review of all assessment materials, medical and service records and/or the past year's progress and the participant's ongoing needs.
- A review of waiver services, state plan and other services available to the participant and how they relate to and will support ~~his or her~~their needs and goals.
- Identification of additional assessments, if any, needed to inform the service planning process.

Other preparation includes at the direction of the participant, talking to people who know the participant well such as staff, friends, advocates, and involved family members. In selecting people to talk to, the Case Manager respects the participant's wishes about who is part of the service planning process. When participants cannot communicate their preferences, Case Managers collect information through observation, inference from behavior, and discussions with people who know the participant well. All conversations are respectful of the participant and focus on the person's strengths and preferences. The Case Manager also looks for creative ways to focus the team on the unique characteristics of the person and ~~his (or her)~~their situation. The Case Manager does this by helping team members think creatively about how they can better support the person within the context of the participant's strengths, abilities and preferences.

During the service planning consultation, the participant identifies who will be invited to the meeting. These individuals constitute the team members. In situations where personal and sensitive issues are discussed, certain team members may be invited to only part of the meeting, as the participant prefers. Any issue about attendance at the service planning meeting is addressed by the Case Manager based upon the preferences of the participant and or guardian.

d. Service Plan Development Process In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Case Managers will follow standard procedures and time frames in performing the intake, assessment, case conferencing, service planning and review process that ensure participants' strengths, needs, risk factors, personal goals and preferences are identified and appropriately addressed. Throughout the following description of the service plan development process, any reference to the participant implies reference to the participant's guardian where one is in place.

Participant needs are identified beginning at referral and continuing through the person-centered service needs assessment and the POC development processes. Through the person-centered planning process and using a state-approved tool, the assessment gathers information on a participant's goals, capabilities, medical/skilled nursing needs, support/service needs and need for skill development and/or other training to enhance community integration and increase independence, including the opportunity to seek employment, engage in community life and control of personal resources. The service needs assessment will reflect the residential setting that has been chosen by the waiver participant. The process also identifies informal supports available to the participant and all other resources that may be available to assist the participant in remaining in the community, achieving positive outcomes and avoiding unnecessary utilization of waiver services.

The initial service needs assessment is conducted by a Case Manager, and then based on this assessment the participant, if they agree, may be referred to other professionals, such as a registered nurse, psychiatrist, therapist or neuropsychologist for further assessment and identification of needs.

Those participants who have identified behavioral issues will undergo an initial behavioral assessment and, as indicated, periodic reviews. Should a behavior support plan be indicated it will be developed only by a licensed clinician and implemented under the clinician's guidance, with the informed consent of the participant or, when applicable, ~~his or her~~their guardian.

Behavior support plans should also include target behaviors that may also be addressed through prescribed psychotropic medications. Behavior support plans must always be cognitively accessible, and must be reviewed with and signed by the participant and, when applicable, ~~his/her~~their legal guardian.

If the assessment process identifies the need for any modifications of the requirements for provider-owned or controlled residential settings the service plan development process shall:

document the specific and individualized assessed need for the modifications; document other interventions and supports used prior to any modifications; include a timeline and process for the collection and review of data measuring the effectiveness of the modifications; and include an assurance that the interventions and supports will cause no harm to the participant. Any modifications must be reviewed with and signed by the participant and, when applicable, ~~his/her~~their legal guardian.

Linked to the participant's vision, goals and needs, the Case Manager facilitates development of the service plan with the participant. Participant's guardians and other formal and informal supports identified by the participant are part of the service planning process. This may include providers with knowledge and history of serving the participant. The Case Manager is responsible for providing information about non-waiver services and supports to address identified needs and to prevent the provision of unnecessary or inappropriate waiver services, coordinating and communicating service plans and/or changes to appropriate community agencies and ensuring that waiver participants have access, as appropriate, to waiver and Medicaid State plan services. The Case Manager also identifies other public benefits to ensure that waiver participant needs are met.

The Case Manager's responsibilities include: facilitating the service planning process and development of the POC with the participant and ~~his/her~~their guardian, ensuring the final plan is signed by the participant and addresses ~~his or her~~their expressed and assessed needs, monitoring the participant's satisfaction with the plan and assisting to ensure that participant receives the services in the plan, notification to participants/guardians, facilitating subsequent monitoring meetings, meeting routinely with the participant to assess the participant's progress towards identified goals and making POC changes with the participant as necessary or as requested by the participant.

The Case Manager ensures that the participant receives a copy of the plan of care. The Case Manager also ensures that a 24-hour back up plan is created, and that the participant understands and is able to implement the 24-hour back up plan when necessary.

During the service planning process and development of the POC, the Case Manager identifies specialized assessments or evaluations that should be completed, and assists the participant to identify their preferred Care Plan Team members. The Case Manager explains programs and services to the participant/guardian, including explaining the opportunity to self-direct certain waiver services, and assists ~~him or her~~them in selecting waiver services and Medicaid state plan services which address the participant's needs and expressed goals.

The participant/guardian may choose to identify other people, for example a representative such as a family member or friend, to be present for the assessment visit and subsequent service planning meetings. The waiver participant/guardian may also choose to exclude individuals from the service plan development process. If the primary language of the program participant, or ~~his/her~~their legal guardian, is not English, the information in service plans must be translated into ~~his/her~~their primary language and/or explained with the assistance of an interpreter, including ASL. If the program participant is unable to read or exhibits other cognitive deficits (e.g. memory disorder) which may compromise ~~his/her~~their response to the service plan, and ~~he or she~~they do~~es~~ not have a guardian, alternative methods (e.g. audio-taping) shall be utilized in order to ensure that the information is cognitively accessible.

A Plan of Care that has been signed by the participant/guardian is required in order for the Case Manager to initiate authorization of waiver service. The Plan of Care is reviewed periodically with the participant and ~~his/her~~their Care Plan Team and is modified as needed or as requested and approved by the participant.

The participant will receive a quarterly visit by the Case Manager. The Case Manager may determine that more frequent visits would be beneficial and visit the participant more frequently if ~~he/she~~they agree~~s~~. In addition, if the Case Manager becomes aware of changes in the participant's health condition or living circumstances, ~~s/he~~they may suggest that it would be beneficial for other clinical professionals to visit the participant. The Case Manager will maintain regular contact through a variety of means with the participant between these visits. The POC may be revised at any point by the Case Manager with the approval of the participant/guardian, based on changes in the participant's needs or circumstances.

The Case Manager will document reassessments of the waiver participant in the participant's file. All contact with the participant/guardian, family, vendors and any other persons involved with the participant is also documented in the file.

The Case Manager is responsible for any reasonable accommodations needed for the participant's and family's involvement in the service planning meetings. Accommodations may include personal care assistants, interpreters, peers, translators, physical accessibility, assistive devices, and transportation. These needs may be coordinated and accessed through a waiver service provider involved with the participant.

A very small subset of MFP waiver participants may meet the State's criteria for Targeted Case Management for the mentally ill. For such individuals, the Targeted Case Manager (TCM) would support the individual and coordinate services the person receives through the Department of Mental Health, including such elements as coordinating access to services that DMH provides or contracts for the provision of (which are not duplicative of waiver services), providing supportive counseling, or serving as the person's advocate/supporting the person to advocate for ~~him or herself~~themselves. The TCM will not play a central role in the planning, authorization or monitoring of waiver services for a participant. The administrative case manager will coordinate closely with the TCM in development of the service plan and in other relevant areas in order to ensure both seamless integration and coordination of waiver services with state agency-provided or -contracted services and, importantly, that neither planned/authorized services, nor case management functions are duplicative.

Administratively claimed case management functions will be limited to the establishment and coordination of Medicaid waiver and state plan services focused on the provision of long term services and supports in the community and are not provided through the Massachusetts Department of Mental Health. Administrative case management that will be claimed is an administrative activity necessary for the proper and efficient administration of the State Medicaid plan.

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the

service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Risk assessment and mitigation are a core part of the service planning process. Through multiple assessments, specific to the participant, reviewed during the service planning process, potential risks to the participant's health and safety and the participant's ability to remain in the community are identified by the participant with the case manager's assistance. With the participant, the case manager facilitates with the rest of the Care Plan Team the development of a set of prevention strategies and responses that will mitigate these risks. Having the participant at the center of this process ensures that the responses are sensitive to ~~his/her~~their needs and preferences.

Residential Habilitation, Shared Living - 24 Hour Supports and Assisted Living Services providers are required to have policies and procedures in place to address their:
- Risk Assessment Processes
- Emergency Response and Management Protocols
- Emergency Evacuation Safety Plans
- Participants Elopement from the Program

The participant's case record will specifically include the participant's 24 hour back-up plan. Residential Supports providers will have primary responsibility for participant's 24-hour back-up plan. Potential risk areas identified through the assessment process and the POC identifies services or interventions to mitigate those risks, as necessary and agreed to by the participant. The Case Managers works with the participant's service providers to ensure that the identified risks are appropriately managed. The participant's case record will make note of participants, agencies, and informal supports that provide back-up. The Case Manager communicates the back-up plan to the participant, and ~~his/her~~their guardian/informal supports as appropriate, work with the participant to ensure they know the steps to take to activate the back-up plan.

Participants who are self-directing their services will develop with the Case Manager, a back-up plan to address issues related to their self-direction and to ensure their ability to obtain back-up services as needed. This plan addresses the potential pitfalls and contingencies that must be identified and agreed to with the participant, and is required to be included in both the participant's case record and the participant's Agreement for Self Directed Supports. Broader risk issues related to the participant and their circumstances will be addressed as necessary and appropriate within the participant's case record.

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

As part of the plan of care development process, case management staff review with participants/guardians the range of waiver and non-waiver services available to address the individual's identified needs. The Case Manager works with the participant to identify any specific preferences or requirements, such as a worker who speaks a particular language. The Case Manager makes inquiries regarding the availability of workers, discusses options with the participant (including schedules), and works with the participant to identify the providers best able to meet the requirements and preferences of the waiver participant. The participant ultimately chooses which providers will deliver ~~his/her~~their services. The participant will be advised regarding how to raise concerns about providers and the Case Manager will provide information to the participant regarding how to complain, how to seek assistance from the Case Manager, and how to raise issues with their Program Development and Services Oversight Coordinator if ~~he/she has~~they have a complaint about the Case Manager.

At each visit, Case Managers inquire as to the participant's satisfaction with both the services included in the POC and the service providers. The participant may, at any time, request a change of service providers or Case Manager.

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

DDS will maintain electronic POCs. Additional information may be maintained in a paper record at the Department of Developmental Services Regional Office. Service Plans are reviewed for content, quality, and required components. The sample size is intended to meet requirements of a 95% confidence ~~interval~~ level and a +/-5% margin of error 95/5 response distribution. ~~confidence level.~~ The sample will be randomly generated by a computerized formula which will generate the sample on a quarterly basis throughout the year and it will assure that each Program Development and Services Oversight Coordinator reviews the Service Plans completed by Case Managers from the regions assigned to them.

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

○	**Every three months or more frequently when necessary**
○	**Every six months or more frequently when necessary**
☑	**Every twelve months or more frequently when necessary**
○	**Other schedule** *Specify the other schedule*:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies)*:

☑	**Medicaid agency**
☐	**Operating agency**
☐	**Case manager**
☑	**Other** *Specify:*
	The person centered planning documents, Plans of Care and 24 hour backup plans are maintained electronically by DDS. Additionally, electronic service plan records are recorded by case management staff and maintained in the electronic system. All records are maintained for seven years after the date the case is closed. ~~Hard copies of the person centered planning documents, Plans of Care and 24 hour backup plans are maintained in the participant's paper record in the respective DDS regional office. Electronic service plan records are recorded by case management staff and maintained in the electronic system. All records are maintained for seven years after the date the case is closed.~~

Appendix D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The Case Manager has overall responsibility for monitoring the implementation of the service plan to ensure that the participant is satisfied with waiver services, that they are furnished in accordance with the POC, meet the participant's needs and achieve their intended outcomes. This is done through periodic progress and update meetings and ongoing contact with the participant, ~~his/her~~their Care Plan Team, and other service providers as appropriate.

The participant will receive, at a minimum, a quarterly ~~in-person~~ visit by the case manager. Visits are done primarily in person; telehealth may be used to supplement the scheduled in-person visit based on individual needs. The case manager may determine that more frequent visits would be beneficial and visit the participant ~~in-person~~ more frequently if the participant agrees. If the case manager becomes aware of changes in the participant's health condition or living circumstances, they may suggest that it would be beneficial for other clinical professionals to visit the participant. In addition, the case manager will maintain regular contact with the participant through a variety of means between the in-person visits. The POC may be revised at any point by the case manager with the participant, based on changes in the participant's needs or circumstances.

The case manager will review with the participant the range of waiver and non-waiver services available to address the participant's identified needs and ensure access to services. At each in-person visit and telephone contact, the case manager will inquire as to the participant's satisfaction with both the services included in their POC and the service providers. The participant has free choice of service providers and may, at any time, request a change of service providers.

The case manager will ensure that a 24-hour back up plan is created and updated as needed, as a component of the participant's service plan, and that the participant, and ~~his/her~~their guardian/informal supports as appropriate, understands and is able to implement the 24-hour back up plan when necessary. Case managers will work with the participant's service providers to ensure that the identified risks are appropriately managed.

In addition there are several other quality management processes, conducted by other departmental staff as well as providers to assure that individual participants are getting the services they need and that their health and welfare is protected. These processes are described more fully in other appendices~~, and include but are not limited to~~:
a) incident reporting and management (described in Appendix G)
b) medication occurrence reporting (described in Appendix G)
c) investigations process (described in Appendix G)
d) "trigger" reports (described in Appendix G)
e) bi-monthly site visits f) risk assessment and management system
g) human rights and peer review processes
h) licensure and certification system
i) annual standard contract review process
j) periodic progress and update meetings
k) on-going contact with the participant and service providers.
Through the web-based incident reporting and management system, Case Managers are notified of incidents that occur for individuals on their caseload. The system, known as the Home and Community Services Information System (HCSIS) alerts Case Managers in a timely manner, to any

reportable event. Case Managers are required to review and approve action steps taken by the reporting provider. Incidents may not be "closed" until such time as action steps have been approved. In addition, Case Managers receive monthly "trigger" reports, which identify individuals who have reached a certain threshold of incidents. Case Managers are required to review all "trigger" reports to assure that appropriate action has been taken to protect the health and welfare of participants.

The Department also has an extensive risk management system. Risk management teams identify, assess and develop risk management plans for individuals identified who require specific supports in order to mitigate risk to health and safety. Plans are reviewed on a regular basis by the Risk teams to assure their continued efficacy.

Frequency of ~~direct in-person~~ contact with the waiver participant is at least quarterly, with additional visits based on individual needs. Contact is primarily done in person; telehealth may be used to supplement the scheduled in-person visit based on individual needs. The amount of ~~direct~~ contact is related to a number of variables including participant interest, whether the participant has a risk plan in place, the number of potential providers who have daily contact with the participant, the frequency of program monitoring activities within the provider site, the frequency and type of family monitoring etc. In response to incidents reported through HCSIS the system produces “trigger reports” which provide additional information to the Case Manager about the need to potentially increase direct in-person contact. Individuals with changing needs may be seen more frequently in order to ensure continuity and to monitor potential changing situations. Case Managers review progress notes from providers and maintain regular contact with providers of waiver services which also serves to inform the frequency of direct in-person contact. Individuals who have not received at least one waiver service monthly, receive direct in-person contact in the following month.

DDS uses the Supervisor Tool to monitor the access to all needed services on a quarterly basis. Program Development and Services Oversight Coordinators routinely review Case Manager notes to monitor participant access to non-waiver services in the service plan including health services.

Case Managers also conduct bi-monthly site visits of 24 hour residential supports. Case Managers utilize a standardized site visit form that reviews such issues as the condition of the homes, interactions and knowledge of staff of the individual and ~~his/her~~their needs, and whether the individual's health and clinical needs are being addressed. Issues are identified and follow up is conducted by either the Case Manager, program development and service oversight coordinator or other identified regional office staff.

DDS also requires all residential providers to maintain active human rights committees as well as site based human rights officers. Human rights committees review all behavioral interventions to assure that participants' rights have been reviewed and safeguarded. The human rights committee~~s~~ function to ~~insure~~ ensure that the behavioral interventions described and the data collected present a coherent plan and that the treatment is effective. DDS as part of its Survey and Certification process reviews whether all behavioral interventions have all required components and have undergone all required reviews. This includes 1) the composition of the Human Rights Committee. 2) obtaining informed consent from the individual and/or guardians, 3) assuring that all behavior plans are in written format, 4) whether all behavior plans have all the required components, 5) reviewed all of the required reviews which include the POC team, the Human Rights Committee, individual and/or guardian, Peer Review and a Physician Review, 6) that the data is maintained and used to determine the efficacy of the intervention and that 7) restrictions for one individual do not impinge on the rights of other individuals.

Case Managers conduct quarterly reviews of the service plan and its continued efficacy in assisting individuals to reach their goals and objectives. Providers submit progress reviews and modifications may be made if deemed necessary.

b. Monitoring Safeguards. *Select one:*

☑	**Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
○	**Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.** The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify*:

Quality Improvement: Service Plan

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. **Methods for Discovery: Service Plan Assurance**

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-assurances:

a. Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

i. Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	% of service plans that reflect needs identified through the assessment process. (Number of service plans that address needs identified during the assessment process/ Number of service plans reviewed)
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify: **SC Supervisor Tool**	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☑ *Less than 100% Review*
	☐ *Sub-State Entity*	☑ *Quarterly*	☑ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	95% margin of error +/-5 95/5 response distribution
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☑ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	% of service plans that have been developed in accordance with waiver requirements as indicated by the inclusion of all required components, including all required assessments, support strategies, choice forms, LOC & POC. (Number of service plans developed in accordance with waiver requirements as indicated by the inclusion of all required components/ Number of service plans reviewed)

Data Source *(Select one) (Several options are listed in the on-line application):*

If 'Other' is selected, specify: **SC Supervisor Tool**

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☑ *Less than 100% Review*
	☐ *Sub-State Entity*	☑ *Quarterly*	☑ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	95% margin of error +/-5 95/5 response distribution
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☑ *Annually*
	☐ *Continuously and Ongoing*

State:	
Effective Date	

	☐ *Other Specify:*

Performance Measure:	% of service plans that reflect personal goals identified through the assessment process. (Number of service plans that address personal goals identified during the assessment process/ Number of service plans reviewed)

Data Source *(Select one) (Several options are listed in the on-line application):*

If 'Other' is selected, specify: **SC Supervisor Tool**

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☑ *Less than 100% Review*
	☐ *Sub-State Entity*	☑ *Quarterly*	☑ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	95% margin of error +/-5 95/5 response distribution
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☑ *Annually*

	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	% of service plans in which communication and contact has been maintained as required to assure that services are being provided and meet the person's needs. (Number of service plans in which communication and contact has been maintained as required to assure that services are being provided and meet the person's needs / Number of service plans reviewed)
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify: **SC Supervisor Tool**	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☑ *Less than 100% Review*
	☐ *Sub-State Entity*	☑ *Quarterly*	☑ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	95% margin of error +/-5 95/5 response distribution
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*

State:	
Effective Date	

☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☑ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

b. Sub-assurance: The state monitors service plan development in accordance with its policies and procedures.

i. Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	No longer needed in new QM system
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☑ *Other Specify:*	☐ *Annually*	
	No longer needed	☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☑ *Other*	

		Specify:		
		No longer needed		☑ *Other Specify:*
				No longer needed

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☐ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☑ *Other Specify:*	☐ *Annually*
No longer needed	☐ *Continuously and Ongoing*
	☑ *Other Specify:*
	No longer needed

Add another Performance measure (button to prompt another performance measure)

c. Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.

i. Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	% of service plans that are completed and/or updated annually. (Number of service plans completed and/or updated annually/ Number of service plans reviewed)
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify: **SC Supervisor Tool**	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☑ *Less than 100% Review*
	☐ *Sub-State Entity*	☑ *Quarterly*	☑ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	95% margin of error +/-5 95/5 response distribution
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☑ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	% of service plans updated when warranted by changes in participants' needs. (Number of service plans updated when needs change/ Number of participants reviewed with changing needs)
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify: **SC Supervisor Tool**	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☑ *Less than 100% Review*
	☐ *Sub-State Entity*	☑ *Quarterly*	☑ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	95% margin of error +/-5 95/5 response distribution
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☑ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

d. Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.

i. Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	% of individuals who are receiving services according to the type, amount, frequency, duration and scope identified in their plan of care. (Number of individuals who are receiving services according to the type, amount, frequency, duration and scope in their plan of care/ Number of individual plans of care reviewed)
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify: **SC Supervisor Tool**	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☑ *Less than 100% Review*
	☐ *Sub-State Entity*	☑ *Quarterly*	☑ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	95% margin of error +/-5 95/5 response distribution
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis	***Frequency of data aggregation and analysis:***

State:	
Effective Date	

(check each that applies	*(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☑ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

e. Sub-assurance: Participants are afforded choice between/among waiver services and providers.

i. Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	% of service plans that contain documentation indicating that participant was informed of ~~his/her~~their choice between service providers and method of service delivery. (Number of service plans that contain documentation indicating that participant was informed of ~~his/her~~their choice between service providers and method of service delivery/ Number of service plans reviewed)
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify: **SC Supervisor Tool**	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*

	☑ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☑ *Less than 100% Review*
	☐ *Sub-State Entity*	☑ *Quarterly*	☑ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	95% margin of error +/-5 95/5 response distribution
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☑ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Program Development and Services Oversight Coordinators will review a sample of service plans of each of the service coordinators they supervise utilizing the SC Supervisor Tool. The tool has two components. The first is a checklist that is completed with every service plan submitted for review and approval. The second is a qualitative review which includes discussion with the service coordinator as well as review of supplementary material. This will be done on a quarterly basis. Included will be a

review of documentation (including service coordinator notes, site visit forms, and the service plan) and discussion with the service coordinator to verify that service planning and implementation requirements have been met. Each indicator on the tool will be rated according to whether it met the applicable standard.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

The Department of Developmental Services (DDS) and MassHealth are responsible for ensuring effective oversight of the waiver program, including administrative and operational functions performed by the Level of Care entity and the Administrative Service Organization. As problems are discovered with the management of the waiver program, the Administrative Services Organization, or waiver service providers, the Department of Developmental Services (DDS) and MassHealth/DDS will ensure that a corrective action plan is created, approved, and implemented within appropriate timelines. Timelines for remediation will be dependent on the nature and severity of the issue to be addressed. Further, MassHealth is responsible for identifying and analyzing trends related to the operation of the waiver and determining strategies to address quality- related issues.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	**Responsible Party** *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☑ **State Medicaid Agency**	☐ **Weekly**
	☐ **Operating Agency**	☐ **Monthly**
	☐ **Sub-State Entity**	☐ **Quarterly**
	☐ **Other** Specify:	☑ **Annually**
		☐ **Continuously and Ongoing**
		☐ **Other** Specify:

c. *Timelines*

When the state does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

☑	**No**
○	**Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request):*

☑	**Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
○	**No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

○	**Yes. The state requests that this waiver be considered for Independence Plus designation.**
☑	**No. Independence Plus designation is not requested.**

Appendix E-1: Overview

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Subject to the limits ~~to be~~ described in the waiver application, participants in this waiver may lead the design of their service delivery through participant direction. The Case Manager will provide consumer-directed service options for participants who choose to self-direct one or more services within their Plan of Care (POC) and to have choice and control over the selection and management of waiver services and providers. Participants may choose employer authority which will provide participants the opportunity to hire, manage and dismiss their own workers for certain services. Once eligibility has been established, and as part of the initial and on-going planning process of assessment and enrollment into the waiver, the individual is provided information by the Case Manager about the opportunity to self-direct. The Case Manager will describe the responsibilities of employer authority, the role of representatives and the availability of skills training and support for those choosing a participant-directed model of care.

Each year at the time of the Plan of Care (POC) development process, participants will be given the opportunity to self-direct certain services as specified in this application. The Case Manager will assess, based on established criteria, the participant's ability to self-direct and what supports may be needed to ensure success.

Each individual who self-directs will have a Case Manager to assist ~~him/her~~them ~~to~~ in developing the waiver plan of care~~,~~ and assist ~~him/her~~them ~~to~~ in directing and managinge~~~~ that part of their plan of care that will be self-directed. The Case Manager will assist individuals to access community and natural supports and advocate for the development of new community supports as needed. The Case Manager will ensure that the participant receives necessary support and training on how to hire, manage and train staff and to negotiate with service providers.

A variety of supports are available to assist participants who choose this model. The Case Manager determines whether the participant is able to carry out the responsibilities of an employer without assistance. Participants who require assistance must appoint a representative. Any participant may elect someone to act as ~~his or her~~their representative and assume responsibility for employer functions that the participant cannot or chooses not to perform. The Case Manager assists the participant and/or representative in POC development, identification of worker tasks and completion of required forms. In addition, the Case Manager will provide or arrange for skills training to the participant and/or representative on employer functions and will link them to other needed resources such as worker training.

Individuals who self-direct and hire their own workers will sign an Agreement for Self-Directed Supports and have the authority and responsibility to undertake the following tasks: recruit and hire workers, verify qualifications, determine workers duties, provide training and supervision, evaluate staff, maintain and submit time sheets, ~~pay the worker,~~ submit employee data to the Fiscal Management Service Agency (FMS) as required, and, if necessary, terminate a worker's employment. Once the POC is complete, information regarding the authorized frequency and duration of the participant-directed services in the POC is forwarded to a FMS.

The FMS performs the payment tasks associated with the employment of a participant's waiver service worker. The participant functions as the common law employer, while the FMS provides fiscal services related to income tax and social security tax withholding and state worker compensation taxes. The FMS assists participants in verifying worker citizenship status and conducts the Criminal Offender Record Information (CORI) check. The FMS collects and processes the participant's time-sheets.

The worker ~~may~~ must elect~~, as most workers do,~~ to have the FMS direct deposit payment into the worker's bank account in which case, the participant will notify the FMS to do so. The worker may choose to apply for a payroll debit card to receive payment. ~~In rare cases where the worker does not choose direct deposit, the FMS will issue appropriate checks in the name of the worker and will mail the check to the waiver participant who will distribute the check to the worker.~~

The FMS is responsible for tracking time worked to enable MassHealth to calculate payments to be made in accordance with FLSA requirements, including but not limited to payments for overtime. In addition, the FMS will track the accumulation of earned paid~~sick~~ time to enable MassHealth to make ~~sick~~ earned paid time payments ~~in accordance with~~ and which satisfies the requirement of the Massachusetts sick time law at Massachusetts General Law chapter 149, section 148C.

The FMS is required to be utilized by participants and families who choose employer authority to hire their own staff and self-direct some or all of their waiver services in their POC. ~~Each calendar year, there must be one FMS entity that is related to each worker in order to comply with IRS tax code requirements.~~ The FMS functions will be recognized as administrative costs.

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one:*

☑	**Participant – Employer Authority**. As specified in ***Appendix E-2, Item a,*** the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

○	**Participant – Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
○	**Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

☑	**Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
☑	**Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
☑	**The participant direction opportunities are available to persons in the following other living arrangements** *Specify* these living arrangements: Persons residing in a leased apartment, with lockable access and egress, and which includes living, sleeping, bathing and cooking areas over which the individual or individuals' family or guardian has domain and control.

d. Election of Participant Direction. Election of participant direction is subject to the following policy (s*elect one):*

○	**Waiver is designed to support only individuals who want to direct their services.**
○	**The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
☑	**The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.** *Specify the criteria* Self-direction opportunities will be available to all participants enrolled in the waiver. Participants must express their desire to self-direct services and may be assessed for their need for a surrogate to assist them to self-direct. The need for surrogacy will be assessed during the service planning process by the care planning team and reviewed annually. If it is determined the participant needs a surrogate, the participant will seek a voluntary surrogate from family, friends, or other sources. If there is no resource who can serve as a voluntary surrogate, the Case Manager will work with the participant to determine if Individual Support and Community Habilitation services can provide surrogacy support to the participant. The Case Manager will provide or arrange for skills training to the participant or participant's unpaid surrogate and assist the participant/surrogate in on-going management of the self-directed supports. Should evidence arise that a participant who is self-directing ~~his/her~~their services is no longer able to do so, theys~~/he~~ will be offered the option to have a surrogate, as described above, to assist with their self-direction decisions. If a participant who has been assessed to require surrogacy does not wish to use or continue to use a surrogate they~~he/she~~ will not be able to self-direct and will transition to receiving supports through a traditional provider. Appeal rights will be granted.

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

As part of the intake and waiver eligibility process, information about the waiver and opportunities for self-direction will be provided to each individual. The range of options will be discussed as part

of the person-centered planning process and throughout the implementation of the POC by the Case Manager. The Case Manager will provide written materials to the participant describing both the benefits and potential liabilities of self-direction, and the role of the Fiscal Management Service in managing these services. When a participant elects to self-direct some of their services, additional information and a handbook about the Fiscal Management Service (FMS) and the requirements for self-directing will be provided, including information about the Agreement for Self-Directed Supports. The FMS has the responsibility for providing fiscal services related to income tax and social security tax withholding, and state worker compensation taxes.

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one)*:

○	**The state does not provide for the direction of waiver services by a representative.**
☑	**The state provides for the direction of waiver services by representatives.** Specify the representatives who may direct waiver services: *(check each that applies)*:
☑	**Waiver services may be directed by a legal representative of the participant.**
☑	**Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

The state's practice is to allow Waiver Participants the opportunity to self-direct their waiver services independently if they are able to do so, or with assistance if needed from a non-legal representative chosen by the Waiver Participant.

The Case Manager will provide support as needed to the Waiver Participant to ensure that proper safeguards are in place to ensure effective oversight and implementation of the POC.

The Waiver Participant and the Participant's non-legal representative delineate agreed upon responsibilities of the representative in the Agreement for Self-Directed Supports.

The Case Manager will address any concerns they have about self-directed services through regular meetings with the Waiver Participant and their representative. In addition, meetings can occur anytime an issue or concern arises.

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3. *(Check the opportunity or opportunities available for each service)*:

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Individual Support and Community Habilitation	☑	☐
Peer Support	☑	☐

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

☑	**Yes**. **Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

	Specify whether governmental and/or private entities furnish these services. *Check each that applies:*
☐	**Governmental entities**
☑	**Private entities**
○	**No**. **Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. S*elect one*:

○	FMS are covered as the waiver service specified in Appendix C-1/C-3 **The waiver service entitled:**	
☑	**FMS are provided as an administrative activity.** ***Provide the following information***	
i.	**Types of Entities**: Specify the types of entities that furnish FMS and the method of procuring these services:	
	Financial Management Service (FMS) will be provided through a financial management service entity. These services are procured in accordance with state procurement laws.	
ii.	**Payment for FMS**. Specify how FMS entities are compensated for the administrative activities that they perform:	
	The FMS will be furnished as an administrative activity. The administrative fee is set by MassHealth through the FMS contract and is paid on a per person per day basis for each participant who chooses to self-direct. The FMS contract requires that MassHealth conduct an annual reconciliation of the fee to determine whether or not it is sufficient. Each human and social service organization that delivers services to the Commonwealth's consumers via contracts with state departments is required to complete and submit annual Uniform Financial Statements and Independent Auditor's Report (UFR). MassHealth uses each FMS's annual UFR to compare the FMS's reasonable expenditures for administrative tasks identified in the UFR and paid claims to determine if the FMS expenditures fall within 90% - 110% of the total MassHealth reimbursement. If the FMS reasonable expenditures exceed the reimbursement by more than 10% of what MassHealth has paid, then MassHealth will pay the FMS the amount exceeded, and the rate would most likely be increased. If the reconciliation process shows that FMS expenditures fall below 90% of what they were paid, then the FMS would owe MassHealth, and the rate would be decreased. If the expenditures fall within the 90% - 110% range then no action is needed and no money is either returned or paid out.	
iii.	**Scope of FMS**. Specify the scope of the supports that FMS entities provide *(check each that applies):*	
	Supports furnished when the participant is the employer of direct support workers:	
☑	**Assists participant in verifying support worker citizenship status**	
☑	**Collects and processes timesheets of support workers**	
☑	**Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**	
☑	**Other** *Specify:*	

		The FMS conducts the CORI and List of Excluded Individuals and Entities (LEIE) checks. The worker may elect to have the FMS direct deposit payment into the worker's bank account in which case, the participant will notify the FMS to do so. The worker may also choose to receive their payment via a debit card. ~~If the worker does not elect direct deposit, the FMS will issue appropriate checks in the name of the worker and will mail the check to the waiver participant who will distribute check to the worker.~~ The FMS also provides periodic reports to the participant and case manager regarding utilization of participant-directed services.
	Supports furnished when the participant exercises budget authority:	
	☐	**Maintains a separate account for each participant's participant-directed budget**
	☐	**Tracks and reports participant funds, disbursements and the balance of participant funds**
	☐	**Processes and pays invoices for goods and services approved in the service plan**
	☐	**Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
	☐	**Other services and supports** *Specify*:
	Additional functions/activities:	
	☑ ~~☐~~	**Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
	☑	**Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
	☐	**Provides other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**
	☑	**Other** *Specify:*
		The FMS issues worker payments by automatic direct deposits, unless the worker is authorized to receive payment by payroll debit card, on a biweekly basis. ~~In cases where the worker does not elect direct deposit, the FMS will issue appropriate checks in the name of the worker and will mail the check to the MFP waiver participant who will distribute the check to the worker. The worker may elect to have the FMS direct deposit payment into the worker's bank account in which case, the participant will notify the FMS to do so.~~ The FMS also provides periodic reports to the participant and case manager regarding utilization of participant-directed services.
iv.	**Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions	

	that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.
	The State will manage the performance of the FMS via contract. The State will establish performance metrics as part of the FMS contract and will require that its FMS meet them and have an established process of remediation if they do not achieve them. Monthly FMS reports will reconcile expenditures for a participant with that participant's approved plan of care. The FMS is also required to maintain a log of complaints.

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☑	**Case Management Activity**. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. *Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*	
	Each participant who desires to self-direct their services will be assessed to determine their capacity to do so and the types of supports that will be required to assist them. Each Participant will have a Case Manager to provide information and assistance to support self-direction. The Case Manager will monitor the implementation of the support plan and provide coordination and oversight of supports. The role of the Case Manager in individual planning is to support the person and other team members to develop and implement a plan that addresses the participant's needs and preferences. Case Managers support participants to be actively involved in the planning process, share information about choice of qualified providers and self-directed options, and assist with arranging supports and services as described in the plan. They also support the participant to monitor services and make changes as needed. The Case Manager may also support participants to: - hire, train and manage their employees; - develop emergency back up plans; and - access and develop self-advocacy skills. Case Managers are responsible for ensuring that participants understand their responsibilities under self-direction and that the participant has signed the Agreement for Self-Directed Supports.	
☐	**Waiver Service Coverage**. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-1/C-3 (check each that applies):	
	Participant-Directed Waiver Service	**Information and Assistance Provided through this Waiver Service Coverage**
	(list of services from Appendix C-1/C-3)	☐
☑	**Administrative Activity**. Information and assistance in support of participant direction are furnished as an administrative activity. *Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and (e) the entity or entities responsible for assessing performance:*	
	Each participant who desires to self-direct their services will be assessed by ~~his/her~~their case manager to determine their capacity to do so and the types of supports that will be required to assist them. Each Participant will have a Case Manager to provide information and assistance to support self-direction. The Case Manager supports the participant or their legal representative in arranging for, directing, and managing waiver services. Assistance is provided in identifying immediate and long-term needs, developing options to meet those needs and accessing identified waiver supports and	

	waiver services. Participants or their representatives may also receive information on recruiting and hiring direct service workers, managing workers and providing information on effective problem solving and communication. The Case Manager function includes providing information to ensure that the participant or representative understands the responsibilities of directing their own services; the extent of assistance needed by the participant is discussed by the team and specified in the service plan. The Case Manager will assist in developing the self-direction specifics of the POC to ensure that the needs and preferences are clearly understood and reflected in the plan and will ensure the participant receives skills training, if needed, to enable ~~him/her~~them to arrange for, direct and manage waiver services. The Case Manager will focus on the following sets of activities in support of participant-directed services: - Support the individual to recruit, train and hire staff; - Facilitate community access and inclusion opportunities; - Monitor and assist the individual participant when revisions to the POC are needed; and - Support the participant in working with the Fiscal Management Service to recruit, screen, hire, train, schedule, monitor and pay support workers.

k. Independent Advocacy *(select one)*.

☑	**No. Arrangements have not been made for independent advocacy.**
○	**Yes**. Independent advocacy is available to participants who direct their services. *Describe the nature of this independent advocacy and how participants may access this advocacy*:

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

Repeated efforts will be made by the Case Manager to sustain the participant in ~~his/her~~their self-direction of services. If after multiple efforts, the waiver participant voluntarily chooses to terminate this method of receiving services, it is the Case Manager's responsibility to arrange for and ensure continuity of services/supports through traditional providers to meet the individual's health and welfare needs outlined in their participant-centered plan of care. When appropriate, the Case Manager will work with the participant to adjust the POC to ensure that it meets the needs and desires of the participant and to ensure health and safety during the transition from participant-directed services to more traditional provider based services.

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

In the case of an involuntary termination of participant direction, the individual and the support team meet to develop a transition plan and modify the Waiver Plan of Care. The Case Manager ensures that the participants' health and safety needs are met during the transition, coordinates the transition of services and assists the individual to choose a qualified provider to replace the directly hired staff.

Although the State will work to prevent situations of involuntary termination of self-direction, they may be necessary. Reasons for involuntary termination of self-direction will include (but not be limited to) such things as refusal on the part of the participant to be involved in the development

and implementation of the Individual Service Planning Process, the participant authorizing payment for services or supports that are not in accordance with the plan of care, the participants commission of fraudulent or criminal activity associated with self-direction, demonstration that the participant requires a surrogate to ensure adequate management of workers, but declines such surrogate when informed one is necessary in order to self-direct, on-going inability to locate, supervise, and retain employees, and/or to submit time-sheets in a timely manner, and other individual circumstances that may preclude continued self-direction.

Each participant who self-directs will have an Agreement for Self-Directed Supports describing the expectations of participation. As part of this agreement, the individual acknowledges that the authorization and payment for services that are not rendered could subject them~~him/her~~ to Medicaid fraud charges under state and federal law. Breach of any of the requirements with or without intent may disqualify the individual from self-directing-services. Termination of the participant's self-direction opportunity may be made when a participant or representative cannot adhere to the terms of the Agreement for Self-Directed Supports.

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	**Budget Authority Only or Budget Authority in Combination with Employer Authority**
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	~~6~~3	
Year 2	~~12~~3	
Year 3	~~18~~3	
Year 4 (only appears if applicable based on Item 1-C**)**	~~23~~3	
Year 5 (only appears if applicable based on Item 1-C**)**	~~29~~3	

Appendix E-2: Opportunities for Participant-Direction

a. Participant – Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both:*

☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. Specify the types of agencies (a.k.a., "agencies with choice") that serve as co-employers of participant-selected staff:
☑	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☑	**Recruit staff**
☐	**Refer staff to agency for hiring (co-employer)**
☑	**Select staff from worker registry**
☑	**Hire staff (common law employer)**
☑	**Verify staff qualifications**
☐	**Obtain criminal history and/or background investigation of staff** Specify how the costs of such investigations are compensated:
☑	**Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3. Specify the state's method to conduct background checks if it varies from Appendix C-2-a:**
	Criminal background checks are conducted in accordance with processes outlined in Appendix C-2-a.
☑	**Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
☐	**Determine staff wages and benefits subject to applicable state limits**
☑	**Schedule staff**
☑	**Orient and instruct staff in duties**

☑	**Supervise staff**
☑	**Evaluate staff performance**
☑	**Verify time worked by staff and approve time sheets**
☑	**Discharge staff (common law employer)**
☐	**Discharge staff from providing services (co-employer)**
☐	**Other** Specify:

b. Participant – Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more***:**

☐	**Reallocate funds among services included in the budget**
☐	**Determine the amount paid for services within the state's established limits**
☐	**Substitute service providers**
☐	**Schedule the provision of services**
☐	**Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
☐	**Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
☐	**Identify service providers and refer for provider enrollment**
☐	**Authorize payment for waiver goods and services**
☐	**Review and approve provider invoices for services rendered**
☐	Other Specify:

ii. Participant-Directed Budget. Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

iv. Participant Exercise of Budget Flexibility. *Select one:*

○	**Modifications to the participant directed budget must be preceded by a change in the service plan.**
○	**The participant has the authority to modify the services included in the participant-directed budget without prior approval.** Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Waiver applicants and participants are afforded the opportunity to request a fair hearing disputing actions under the MFP-CL Waiver in all instances when: (1) they are not provided the choice of home and community-based services as an alternative to institutional care; (2) they are denied participation in the MFP-CL Waiver; (3) there is a denial, suspension, reduction or termination of services, including a substantial failure to implement the services contained in their Individual Service Plan, within the terms and conditions of the MFP-CL Waiver as approved by CMS.

Individuals are informed in writing of the procedures for requesting a Fair Hearing as part of the waiver entrance process. If entrance to the waiver is denied, the person is given formal written notice of the denial and information about how to request a Fair Hearing to appeal the denial of entrance to the waiver. In order to ensure that individuals are fully informed of their right to Fair Hearing, the written information will be supplemented with a verbal explanation of the Right to Fair Hearing when necessary. Appellants are notified that they can seek judicial review of the final decision of the hearing officer in accordance with M.G.L. c. 30A (the Massachusetts Administrative Procedures Act). It is up to the individual to decide whether to request a Fair Hearing.

Whenever an action is taken that adversely affects a waiver participant post-enrollment (e.g., services are denied, reduced or terminated), the participant is notified in writing by letter of the action on a timely basis in advance of the effective date of the action. The notice includes information about how the participant may appeal the action by requesting a Fair Hearing and provides, as appropriate, for the continuation of services while the participant's appeal is under consideration. Copies of notices are maintained in the person's record. It is up to the participant to decide whether to request a Fair Hearing.

The notices regarding the right to appeal in each instance provides a brief description of the appeals process and instructions regarding how to appeal. In addition, the participant’s plan of care is accompanied by right-to-appeal information, as described above, as well as a cover letter that includes contact information for a Case Management staff person who is available to answer questions or to assist the individual in filing an appeal. Regulations of the Executive Office of Administration and Finance at 801 CMR 1.02 et seq. (Executive Office for Administration and Finance regulations establishing standard adjudicatory rules of practice and procedure), shall govern MFP-CL Waiver appeal proceedings.

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one*:

☑	**No. This Appendix does not apply**
○	**Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

☑	**No. This Appendix does not apply**
○	**Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program. *Select one*:

☑	**Yes**. **The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
○	**No**. **This Appendix does not apply** (*do not complete Items b through e).* *If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.*

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents, and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DDS and MRC utilize a web based incident reporting system, based upon the Pennsylvania Home and Community Services Information System (HCSIS) system. The incident reporting system provides invaluable information regarding individual incidents, immediate and long range actions taken as well as aggregate information that informs analyses of patterns and trends. Providers are required to report incidents when they occur and DDS case managers are required to report incidents when they learn about them if they have not already been reported. Incidents are classified as requiring either a minor or major level of review. Deaths, physical and sexual assaults, suicide attempts, certain unplanned hospitalizations, missing person, and injuries are some examples of incidents requiring a major level of review. Suspected verbal or emotional abuse, theft, property damage, and behavioral incidents in the community are some examples of incidents requiring a minor level of review. The HCSIS system is an integrated event system and as such medication occurrences, and any unauthorized use of restraints or restrictive interventions are also reported. These processes are more fully described in this appendix. Incidents classified as requiring a minor level of review must be reported within 3 business days. Minor incidents may be elevated to major, if determined necessary. Incidents requiring a major level of review must be reported within 1 business day, and the provider has the responsibility to immediately report major incidents by phone or e-mail to the case manager. Immediate and longer term actions steps are delineated and must be reviewed and approved by the case manager for minor incidents and by Regional supervisory staff for major incidents. An incident cannot be considered closed until all appropriate parties agree on the action steps to be taken and all required approvals have been completed. Standard management reports for Regional and Central office staff for purposes of follow up on provider and systemic levels are provided on a monthly basis. ~~Each quarter a~~Aggregate data regarding specific incident types are reported

annually. The reports detail both the number of incidents as well as the rate of incidents so that comparisons can be made between Areas, Regions and Statewide.

In addition to the incident reporting system, all alleged instances of abuse, ~~or~~ neglect, exploitation, and/or death must be reported to the Disabled Persons Protection Commission (DPPC) for all individuals between the ages of 18 and 59 and to the Executive Office of Elder Affairs for individuals over the age of 59. DPPC is the independent State agency responsible for screening and investigating or referring for investigation all allegations of abuse, ~~or~~ neglect, exploitation, and/or death for individuals with disabilities between the ages of 18 and 59. Mandated reporters, as well as individuals and families, report suspected cases of abuse, ~~or~~ neglect, exploitation, and/or death directly to the DPPC. DPPC reviews all reports, then determines and assigns investigation responsibility.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

. As part of their responsibility, providers are required to inform all participants and families of their right to be free from abuse and neglect and the appropriate agency to whom they should report allegations of abuse, neglect, ~~or~~ exploitation and/or death. Individuals and their families are given the information both in written and verbal formats. As part of their role, case managers also inform individuals about how to report alleged cases of abuse, ~~or~~ neglect, exploitation, and/or death. Quality Enhancement surveyors conducting licensure and certification reviews check to assure that individuals and guardians have received information regarding how to report suspected instances of abuse, ~~or~~ neglect, exploitation, and/or death. They also check to assure that the information is imparted in the format most appropriate to the individual's or family's learning style.

The ~~recently developed (2017)~~ "Participant Handbook: A Guide for Individuals Receiving Services through the Acquired Brain Injury or the Money Follows the Person Medicaid Waiver Programs" presents information about participants' right to be free from abuse, ~~or~~ neglect, exploitation and how to report any abuse, ~~or~~ neglect, exploitation.

In addition, as part of its ongoing commitment to providing participants with information to prevent and report abuse or neglect, DDS has a number of initiatives designed to strengthen overall reporting in the Department. These DDS initiatives include but are not limited to partnerships with stakeholder and self-advocacy groups such as Massachusetts Advocates Standing Strong to support "Awareness and Action", a training program taught by and for self-advocates regarding how to prevent and report abuse, neglect, exploitation and a partnership with a private provider to train self-advocates in self defense and to support providers to create a culture of zero tolerance for abuse, ~~/~~neglect, exploitation.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

As mentioned in G-1-b, there are two distinct processes for reviewing incidents—one for incidents (classified as requiring a minor or major level of review) and one for reporting of suspected instances of abuse, ~~or~~ neglect, exploitation, and/or death. A reported incident may also

be the subject of an investigation, but the processes are different and carried out by different entities. The processes are described below.
Minor and major incidents must be reported by the staff person observing or discovering the incident. An incident requiring a major level of review must be immediately reported verbally to the case manager. The incident must also be entered into the electronic web based system (HCSIS). A major incident must be reported through HCSIS within 1 business day; a minor incident within 3 business days. The initial report is reviewed by the case manager to assure that immediate actions have been taken to protect the individual. The provider must also submit a final report which includes the follow up action steps that will be taken beyond those already identified. Both minor and major incident reports are reviewed by the case manager. Major incidents are escalated to the regional level for review. The final report, which includes action steps, must be agreed upon by both the provider and DDS. If DDS does not concur with the action steps, the report is sent back to the provider for additional action. Incident reports are considered closed only after there is consensus among the parties as to the action steps taken and all required reviews and approvals are completed. A similar process is in place for response to medication occurrences. In the event of a medication occurrence, the review is completed by the regional Medication Administration Program (MAP) coordinator, who is required to be an RN.

Incidents that rise to the level of a reportable event, ~~i.e.~~ allegation of abuse~~,~~ ~~or~~ neglect, exploitation, and/or death potentially subject to investigation, are reported to the Disabled Persons Protection Commission (DPPC). DPPC receives and reviews all reports and makes the determination as to whether a reported event meets the criteria to require an investigation. It then refers the case to the appropriate agency for investigation. DPPC can decide to conduct the investigation itself, refer the case to the DDS Investigations Unit for investigation, or refer the case to law enforcement entities as the circumstances require. If a report filed suggests that a crime may have been committed, the report is sent to the office of the District Attorney with jurisdiction by the DPPC as a referral. Should the DA decide to pursue the matter criminally, the civil investigation is put on hold, protective services are provided as deemed necessary and law enforcement is assigned to investigate. All reports of abuse~~,~~ ~~or~~ neglect, exploitation, and/or death are processed by trained, experienced staff. When deemed necessary, immediate protective services are put into place to ensure that the individual is safe while the investigation is completed. Once referred for investigation, investigators have 30 days to complete their investigation and issue findings. Upon request, the alleged victim, the alleged abuser, and the Reporter can receive a copy of the report. Completed investigations are referred to complaint resolution teams (CRT) comprised of DDS staff and citizen volunteers. It is the CRT's responsibility to develop an action plan and assure that the recommended actions are completed.

In addition, the Human Rights Committee (HRC) for the Residential Habilitation and Shared Living 24 Hour Supports provider agency responsible at the time of the incident is a party to all complaints regarding that agency. In addition to ensuring the alleged victim has access to support for filing complaints of abuse or mistreatment, the HRC is responsible for applying their knowledge of the persons and programs involved and ensuring that any investigation has considered all aspects of the incident. They have the power to appeal the disposition of the complaint, the decisions of the investigation, or the action plan submitted to resolve the investigation. If any major or minor incident appears to involve or impinge on the human rights of an individual, the HRC must be informed of the incident and outcomes.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The responsibility for overseeing the reporting of and response to critical incidents rests with DDS as the operating agency for the waiver. Oversight of the incident management system occurs on three levels- the individual, the provider and the system. As previously mentioned, the incident reporting and management system is a web based system. As such incidents are reported by staff according to clearly defined timelines. The system generates a variety of standard management reports that allow for tracking of timelines for action and follow up as well as for tracking of patterns and trends by individual, location, provider, area, region and state. On an individual level, case managers are responsible for assuring that appropriate actions have been taken and followed up on. On a provider level, Program Development and Service Oversight Coordinators track patterns and trends by location and provider. On a systems level, regional directors and central office senior managers track patterns and trends in order to make service improvements. Licensure and certification staff review incidents and provider actions when they conduct their surveys of residential habilitation and shared living-24 hour supports providers. DDS will forward data on incidents related to specific providers to the Administrative Services Organization (ASO) so that it can incorporate this data into the re-credentialing process for the providers that it credentials.

A ~~central office~~state-wide risk management committee reviews all incident data on a system-wide basis. The committee meets as needed and reviews and analyzes systemic reports generated on specific incident types. Quarterly reports are disseminated to each area and region detailing the numbers and rates of specific incident types. In addition, "trigger" reports based upon 10 thresholds are disseminated to each case manager monthly. This serves as an additional safeguard to assure that responsible staff are aware of, have taken appropriate action when there are a series of incidents that reach the trigger threshold and to follow up on potential patterns and trends for the individuals they support.

In addition to the processes mentioned above, staff in the Office of Quality Management conduct a ~~bi-weekly~~monthly review of key incidents. A report is generated which goes to Regional Risk Managers. In addition, incidents, patterns and trends are communicated to senior DDS leadership as appropriate.~~the bi-weekly report with a synopsis of key incidents is distributed to Senior DDS management staff, including the Commissioner.~~

Finally, on a quarterly basis, a random sample of trigger" reports are selected and reviewed by the Program Development and Services Oversight Coordinator. The sample gets reviewed to determine whether appropriate action was taken, whether the actions were consistent with the nature of the incident and whether additional actions are recommended.

In addition to the processes above, the DDS Director of Risk Management reviews all major incidents and reads certain DPPC reports.

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

a. Use of Restraints *(select one):(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

☑ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

Restraints or seclusion are not allowed in these waivers thus, all such use is unauthorized. While extremely rare, the use of restraint is only permitted in cases of emergency, i.e. the occurrence of serious self-injurious behavior or physical assault or the substantial risk of serious self-injurious behavior or physical assault. Restraint may only be used when a participant is placing themselves or others at risk of imminent danger and there is insufficient time to de-escalate the participant and maintain a safe environment. Restraint techniques are limited to those contained in a EOHHS agency approved crisis prevention, response and restraint (CPRR) curricula; administered by persons trained in the specific restraint utilized; time limited; subject to staff observation and monitoring and reviewed by a provider restraint manager for consistency with regulatory requirements. Restraint debriefings with staff and the participant also are required within specified timeframes and a behavior safety plan is required if frequent restraints occur. Reporting of every restraint on a EOHHS agency approved restraint form in HCSIS also is required. The DDS Commissioner or designee and provider human rights committees review all restraint forms.

DDS utilizes positive behavior supports (PBS), a systemic, person centered approach to understanding the reasons for behavior and applying evidence-based practices for prevention, proactive intervention, teaching and responding to behavior, with the goal of achieving meaningful social outcomes, increasing learning, and enhancing the quality of life across the lifespan. System-wide PBS is utilized to assure the dignity, health, and safety of participants and utilization only of procedures which have been determined to be the least restrictive or least intrusive alternatives.

DDS practices around the use of restraints are consistent with specific parameters contained in DDS regulations and reporting as an incident or to DPPC is required in the event of practice that is inconsistent with DDS regulations.

See 115 CMR 5.00: Standards to Promote Dignity; 115 CMR 3.09: Protection of Human Rights/Human Rights Committees.

~~No use of restraints or seclusion are allowed in the MFP waivers, thus, all such use is unauthorized. While extremely rare, the unauthorized use of a restraint must be reported by providers as an incident in the HCSIS incident reporting system. Providers must also report these incidents to DPPC which screens all allegations of abuse, neglect and mistreatment. Regulations requiring investigation of all reports of abuse and neglect and mistreatment, which would include the unauthorized use of restraints may be found at 118 CMR 5.00 (Regulations for the state's Disabled Persons Protection Commission [the Commission] that define the requirements for abuse investigations conducted by the Commission and the review and oversight standards to be used by the Commission).~~

	~~In addition, surveyors review whether there are any unauthorized use of restraints or restrictive procedures during routine licensure and certification surveys. Finally, case managers review to assure that no unauthorized procedures are utilized during the course of their visits. Review of data reported on incidents provides case managers and Program Development and Services Oversight Coordinators with information that is used to detect any use of restraints or seclusion.~~
○	**The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii:

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

b. Use of Restrictive Interventions

○	**The state does not permit or prohibits the use of restrictive interventions** Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:
☑	**The use of restrictive interventions is permitted during the course of the delivery of waiver services.** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Information contained in this section includes summary information contained in DDS regulations pertaining to the use of restrictive interventions, access to other individuals, etc.

DDS has stringent regulations, standards and policies pertaining to the use of restrictive interventions. DDS utilizes positive behavior supports (PBS), a systemic, person centered approach to understanding the reasons for behavior and applying evidence-based practices for prevention, proactive intervention, teaching and responding to behavior, with the goal of achieving meaningful social outcomes, increasing learning, and enhancing the quality of life across the lifespan. System-wide PBS is utilized to assure the dignity, health, and safety of participants and utilization only of procedures which have been determined to be the least restrictive or least intrusive alternatives.

DDS practices and policy and around the use of restrictive interventions are consistent with DDS regulations and reporting as an incident or to DPPC is required in the event of practice that is inconsistent with DDS regulations.

See (115 CMR 5.00: Standards to Promote Dignity)

~~DDS has very stringent standards pertaining to the use of restrictive interventions. DDS has a stated policy that all interventions designed to modify behavior must be the least restrictive and least intrusive. Interventions are subject to stringent reviews and safeguards. Interventions that are intrusive or restrictive are used only as a last resort and are subject to the highest level of oversight and monitoring. All restrictive interventions must be discussed and approved by the participant or his/her guardian, as part of the person-centered planning process and documented in the Plan of Care. Case managers review the implementation of any restrictive procedures as part of their routine visits, and licensure and certification staff review the use of any interventions considered to be restrictive as part of their licensure surveys.~~

~~DDS is immersed in a major Departmental service improvement initiative to imbed the principles of Positive Behavioral Supports (PBS) into all aspects of its services and supports. This includes training, manuals and tools, and support to providers of service to implement PBS with its three-tier framework for all individuals the Department and its providers support.~~

~~As DDS moves forward with implementing PBS as the primary approach to supporting individuals, it plans to eliminate the current levels, as defined below, and replace them with the more holistic and current standard of practice which PBS represents. Full implementation of PBS into all aspects of services and supports will remain an ongoing focus for the foreseeable future.~~

~~Current important safeguards in the DDS policies pertaining to restrictive interventions continue to be in effect. All behavior plans regardless of the level must be in written form~~

~~and part of the individual's service plan. The plan must include a clear description of the behaviors to treat, specification of how the behavior will be measured, a functional analysis of the antecedents and consequences, the duration and type of intervention, other less restrictive alternatives that have been tried, the name of the treating clinician and a procedure for monitoring, evaluating and documenting the use of the intervention. The levels of intervention currently utilized, include:~~

~~Level I- Positive reinforcement procedures and procedures which may also include aversive properties, neither of which pose any more than a minimal risk of physical or psychological harm and that do not involve significant physical exercise or physical enforcement to overcome the individual's active resistance. Examples include differential reinforcement, satiation, tokens, corrective feedback and social disapproval, relaxation, restitution, ignoring, extinction, and time out not exceeding 15 minutes. The use of the strategy of "extinction," is very similar to "ignoring". It refers to the utilization of strategies designed to ignore the targeted behavior so as not to re-enforce or positively reward it. The intent is to extinguish the use of the behavior and replace it with more positive behavior.~~

~~As examples, restrictive interventions may include locking refrigerator doors for an individual with Prader-Willi syndrome or placing an alarm on a door to alert staff to participants who are prone to elopement and where this would represent concerns for the participant's safety.~~

~~Level II- Any intervention otherwise classified as Level I where the procedure must be enforced over the person's active resistance, or a time out with the individual in the room alone with a closed (but not locked) door for no longer than 15 minutes. No plan may deny an individual adequate sleep, a nutritionally sound diet, adequate bedding, adequate access to bathroom facilities and adequate clothing. All Level II plans must be in written form and must be reviewed and approved prior to implementation by a qualified clinician. In addition, each plan must be reviewed by the provider's human rights committee, (whose composition is prescribed in DDS regulations) and any concerns addressed prior to the implementation of the plan. Each plan is also reviewed by a physician to assure that the intervention is not medically contraindicated. Each plan is also reviewed by a peer review committee composed of three or more clinicians, at least one of whom must be a licensed psychologist. Behavior plans may not be implemented unless informed consent has been obtained from either the individual or his/her guardian. All plans are subject to the requirements of the service planning process and subject to periodic review and appeal procedures.~~

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The Department of Developmental Services has primary responsibility for the monitoring and oversight of restrictive interventions. In addition to the previously mentioned reviews by the care plan team, the human rights committee, and the peer review committee, the use of restrictive interventions is monitored in the following ways:
1) Case managers conduct bi- monthly site visits of Residential Habilitation group home settings and quarterly site visits of Shared Living and Assisted Living settings.
2) Licensure and certification staff conduct an extensive review of interventions to ensure that all of the necessary reviews have been completed confirming that are consistent with DDS regulations, staff is trained, and documentation is properly maintained and

periodically reviewed. Licensure staff will cite areas of concern in reports to providers in the event any of the above requirements have not been met. Follow up will be conducted by licensure and certification.
3) Aggregate data regarding the review, approval and monitoring of procedures collected during the
licensure and certification process is included in DDS Quality Assurance Reports and subject
to review by the statewide quality council for the identification of patterns and trends.
4) Any individual, family member, provider staff or DDS employee may seek the guidance of the DDS
Human Rights Specialist if he/she has any concerns regarding the plan or its implementation.

~~1) Case managers conduct bi- monthly site visits of homes providing 24 hour supports and quarterly visits of homes providing less than 24 hour supports. As part of the visit, case managers check to see whether behavior plans are being appropriately implemented if an individual has one.~~
~~2) Licensure and certification staff do an extensive review of interventions to assure that they have gone through all the necessary reviews, whether they are the least intrusive necessary to meet an individual's needs, whether they are being implemented according to requirements, whether staff has received appropriate training, whether documentation is maintained, and whether it has been reviewed periodically. Licensure staff will cite areas of concern in reports to providers if any of the above requirements have not been met. Follow up is conducted by licensure and certification staff when a pattern or trend is noted.~~
~~3) Any instance of serious physical injury or death of a person who is also the subject of a Level II intervention is reported in the HCSIS database and immediately reported to the Commissioner or designee for review and follow up.~~
~~4) Aggregate data regarding the review, approval and monitoring of interventions collected during the licensure and certification process is included in the Department's Quality Assurance Reports and subject to review by the statewide quality council for the identification of patterns and trends.~~
~~5) Any individual, family member, provider staff or DDS employee may seek the guidance of the DDS Human Rights Specialist if he/she has any concerns regarding the plan or its implementation.~~

c. Use of Seclusion. *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

☑ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The use of seclusion is prohibited and subject to reporting as an incident or to the Disabled Persons Protection Commission.

DDS practices and around the use of seclusion are consistent with specific parameters contained in DDS regulations and reporting as an incident or to DPPC is required in the event of practice that is inconsistent with DDS regulations.

	See 115 CMR 5.00: Standards to Promote Dignity and 9.00: Investigation and Reporting Responsibilities; 13.00: Incident Reporting and 118 CMR 3.00 (DPPC/Reporters) ~~No use of restraints or seclusion are allowed in the MFP waivers, thus, all such use is unauthorized. While extremely rare, the unauthorized use of seclusion must be reported by providers as an incident in the HCSIS incident reporting system. Providers must also report these incidents to DPPC which screens all allegations of abuse, neglect and mistreatment. Regulations requiring investigation of all reports of abuse and neglect and mistreatment, which would include the unauthorized use of seclusion may be found at 118 CMR 5.00 (Regulations for the state's Disabled Persons Protection Commission [the Commission] that define the requirements for abuse investigations conducted by the Commission and the review and oversight standards to be used by the Commission). Case managers review to assure that no unauthorized procedures are utilized during the course of their visits. Review of data reported on incidents provides case managers and supervisors with information that is used to detect any use of restraints or seclusion.~~
○	**The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G-3: Medication Management and Administration

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

○	**No. This Appendix is not applicable** *(do not complete the remaining items)*
☑	**Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

For waiver participants in Residential Habilitation settings the responsibility for monitoring medication regimens is a joint one between providers and DDS staff (specifically, case managers, area office nurses, regional Medication Administration (MAP) coordinators and the care plan team). DDS has an electronic Health Care Record for all individuals that is maintained by providers and case managers and is updated for purposes of the annual service planning process and development of the POC. Included in the health care record is a list of all medications the individual is taking. This allows for review of medications by the care plan team, as well as facilitating thorough communication of relevant medication information to primary health care providers. Provider agency staff monitor the use of medication and side effects on an on-going basis. DDS area office nurses are available for consultation and support to providers when there are questions or concerns about prescribed medications. Direct support professionals are educated about the purpose and side effects of the specific medications individuals they are supporting are taking, and report any issues to the appropriate supervisory and consultant personnel.

Medication management in Assisted Living Residences is overseen by the Executive Office of Elder Affairs in accordance with 651 CMR 12.00 (Department of Elder Affairs regulations describing the certification procedures and standards for Assisted Living Residences in Massachusetts).

DDS requires staff of Residential Habilitation providers to be trained in medication administration through the Medication Administration Program (MAP). After completion of the training by an Approved MAP Trainer, Provider staff are given a knowledge test and a skills test by a third party tester to evaluate their competency to administer medications. Once they pass all components of the test they are certified and authorized to administer medications in MAP registered sites for 2 years. After 2 years they are retested and recertified. Proof of MAP certification for all staff that administer medication is maintained at the program by Provider management.

As part of the licensing process, DDS ~~will~~ provides ongoing oversight and quality management for each residential habilitation provider, including the review of medication records and documentation of physician orders, the dispensing of medications and the assessments of the relative independence of each resident in self-administration. DDS oversight ~~will~~ includes monitoring of the physical management of medications, including locking and storage of all medications. DDS ~~will~~ oversees and track the reporting of all

medication occurrences for each residential program, aggregates the data and identifies trends by residential programs as well as system-wide on a quarterly basis or more frequently if needed. If specific issues are identified, staff will intervenes to clarify procedures, and requires adjustments in operations. If necessary, DDS will develops and monitors adherence to corrective action plans on an individual provider and program basis. DDS has instituted a provider self-monitoring process and will ensures that providers conduct periodic audits utilizing professional/nursing staff from elsewhere within the provider organization, if available, to review their internal operations, methods, and systems of medication administration. DDS Regional MAP Coordinators are also available to assist Providers with compliance issues including program site visits.

DDS requires Shared Living Placement Agencies to have a system in place for oversight of medication administration in each shared living home. The Placement agency must demonstrate that it has an effective mechanism to monitor and oversee medication administration for Shared Living provider homes. MAP training is strongly encouraged even if the Shared Living providers do not become certified. Shared Living providers must be able to demonstrate that they have a system in their home to assure that there are current health care provider orders, side effect information, labeled pharmacy containers, safe storage of medications, and a process to track and document administration of medications.

Shared Living Provider Agencies do monthly site visits of shared living homes to monitor compliance with regulatory requirements and review medication administration. As a part of the licensure and certification surveys, DDS licensure and certification staff review both the system that the Shared Living Provider Agency has in place to monitor medication administration as well as reviewing individual shared living homes to assure that medication is being correctly administered and monitored.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Case managers maintain regular contact with individuals on their caseload and monitor the health status of individuals they are supporting. In addition, through its Health Promotion and Coordination Initiative, DDS has created several processes that facilitate the exchange of information regarding health status and medication regimens between the DDS provider and the health care provider. DDS licensure and certification staff conduct an extensive review of the health care systems that providers have in place to assure coordination, communication and follow up with health care providers on key issues. They also review the level of training and knowledge that direct support professionals have about the health status and medications that the individual is taking. Aggregate data about health and medication use is reported in DDS Quality Assurance Briefs and reviewed by the Statewide qQuality cCouncil.

The Executive Office of Elder Affairs provides oversight for Assisted Living Residence. Oversight in these settings is provided in accordance with 651 CMR 12.00 (Department of Elder Affairs regulations describing the certification procedures and standards for Assisted Living Residences in Massachusetts).

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one*:

○	Not applicable (*do not complete the remaining items*)

☑	**Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Medication administration is allowed in Residential Habilitation, site based respite services and site based day programs that are licensed or operated by DDS. The state medication administration program (MAP) is implemented by the Department of Developmental Services and overseen by the Department of Public Health. Pertinent regulations are 115 CMR 5.15 as well as an extensive policy manual. The MAP program provides for the registration of locations where medication is administered by non-licensed certified staff, identifies the requirements about storage and security of medications, defines the specific training and certification requirements for non-licensed staff, and specifies documentation and record keeping requirements.

Group residences, day programs and short-term site-based respite services are required to obtain a site registration from DPH for the purpose of permitting medication administration by MAP certified staff and the storage of medications on site.

Direct support professionals, including licensed nurses working in positions that do not require a nursing license, must be MAP certified in order to administer medications. MAP certification is valid for two years. Staff must be re-certified every two years. In order to be certified, staff must be trained by an Approved MAP Training using the approved training curriculum of a duration not less than 16 hours, including classroom/online hybrid instruction, testing and a practicum. Trainers must be a registered nurse, nurse practitioner, physician assistant, registered pharmacist or licensed physician who meets applicable requirements as a trainer. Individuals must pass a test consisting of three distinct components (written knowledge, transcription and medication administration) in order to be certified to administer medications. The initial certification is done by an independent contractor, currently D & S Diversified Technologies.

Re-certifications may be done by D & S or by an Approved MAP trainer. MAP certified staff and providers must maintain proof of current MAP certification at the program. An individual's certification may be revoked for cause, after an informal hearing process. A record of revoked certifications is maintained by D & S.

Providers are required to adhere to a strict set of standards with respect to storage of medications, documentation of medication counts at the start and end of each shift, labeling of medications and documentation of medication administration for each individual.

Oversight of the medication administration program is conducted by nurses within provider programs as well as DDS Regional MAP Nurses, known as MAP Coordinators, and the Department of Public Health Clinical Review process.

Self-administration: An individual is determined to be self administering when the medication is under the complete control of the individual with no more than minimal

assistance from program staff. The ability to self-administer medication is determined in conjunction with the individual's care plan team as part of an assessment process. If the individual is determined to be capable of learning to self-administer medication, a teaching plan is developed and documented as part of the service planning process. Once an individual is determined to be self-administering, an oversight system is developed with built in review periods of at least every 3 months. An individual's ability to continue to self-administer medication is reviewed in conjunction with the annual service planning process. Self-administration is applicable to individuals in both 24 hour residential settings as well as shared living settings.

Self-Administration Medication Management (SAMM) is allowed in an Assisted Living Residence if the participant's service plan so specifies. Staff of the Assisted Living who perform SAMM are required to complete Personal Care Service Training as set forth in 651 CMR 12.07(4) or (7)(Department of Elder Affairs regulations describing the certification procedures and standards for Assisted Living Residences); a practitioner, as defined in MGL c. 94C; or a nurse registered or licensed under the provisions of MGL c.112, s. 74 or 74A to the extent allowed by laws, regulations and standards governing nurse practice in Massachusetts MGL c. 94C (the Massachusetts Controlled Substances Act) and MGL c. 112 s. 74 and 74A (which address the regulation of certain professions).
Provider staff:
- remind the participant to take the medication - check the package to ensure that the name on the package is that of the participant
- observe the participant take the medication
- document in writing the observation of the participant's actions regarding the medication
- if requested by the participant, the staff may open prepackaged medication or open containers, read the name of the medication and the directions on the label to the participant, and respond to any questions the participant may have regarding the directions
- staff may assist a participant with SAMM from a medication container that has been removed from its original pharmacy labeled packaging, if the Assisted Living and participant have a full written disclosure of the risks involved and consent by the participant.

iii. Medication Error Reporting. *Select one of the following:*

☑	**Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).** *Complete the following three items:*
	(a) Specify state agency (or agencies) to which errors are reported:
	Residential Habilitation and site-based day programs that are licensed ~~or operated~~ by DDS. Providers are required to file medication occurrence reports (MOR) to the Department of Developmental Services through the HCSIS web-based event reporting system. MOR's that involve any intervention by a health care provider are also reported to the State Department of Public Health. Pharmacy errors get reported to the Board of Registration in Pharmacy. Assisted Living service providers must report medication errors to the Executive Office of Elder Affairs.
	(b) Specify the types of medication errors that providers are required to *record:*
	Residential Habilitation Providers and site-based day programs are required to record a MOR in all of the following circumstances: anytime a medication is given to the wrong person, anytime the wrong medication is given, anytime a medication is given at the wrong time, anytime a wrong dose is given, anytime a medication is administered through the wrong route, or when the medication is omitted.
	(c) Specify the types of medication errors that providers must *report* to the state:
	Residential Habilitation Providers are required to report in all of the following circumstances: anytime a medication is given to the wrong person, anytime the wrong medication is given, anytime a medication is given at the wrong time, anytime a wrong dose is given, anytime a medication is administered through the wrong route, or when the medication is omitted. Shared Living Placement Agencies monitor the medication administration procedures of their individual shared living homes, and take corrective action when necessary. An Assisted Living Residence must report to the Certification Unit at Elder Affairs the occurrence of an incident or accident that has or may have a significant negative effect on a resident's health, safety or welfare. This includes medication errors with an adverse effect requiring medical attention. These reports must be made by telephone and in writing within 24 hours after the occurrence of the incident or accident. Telephone reports are made to a dedicated voice mail line at Elder Affairs and written reports must be faxed to a designated Elder Affairs incident report email address. Reports must include: the nature of the incident or accident; any remedial action taken; the Resident's status at the time the report is made to Elder Affairs; a list of other parties or agencies contacted; and other information as specified in the Assisted Living Certification Standards. Assisted Living staff must document all assistance with medication, including whether or not the participant took the medication and, when applicable, the reason why medication was not taken.
○	**Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.** Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The Department of Developmental Services has primary responsibility of oversight of the Medication Administration Program for programs funded, licensed, or supported by DDS. The Department of Public Health (DPH) also participates in the oversight responsibility. Providers are required to report all medication occurrences within 24 hours of discovery through the HCSIS system. The HCSIS MOR report details the person involved, the type of error, the medications involved, the consultant contacted, any medical interventions that were involved, what followed from the intervention and supervisory follow up action taken. Any MOR that involves medical intervention is also reported to the DPH and is defined as a "hot-line" call. All MOR's get reviewed and approved by DDS regional MAP Coordinators who are registered nurses. Follow-up occurs with providers on all hotline MOR's. This may be accomplished through a phone conversation or a direct site visit, utilizing a Technical Assistance Tool.

On an individual level, MOR's are reviewed by case managers and are part of an integrated review of all incidents that pertain to the individual. Program monitors and Area Directors review MOR information as part of the standard contract review process. Licensure and certification staff do a thorough review of both the medication storage and administration records as well as the certification of staff and their knowledge of the medications and their side effects.

Finally, on a systems level, all information regarding medication occurrences is aggregated and management reports are generated quarterly. These reports detailing the number of medication occurrences including the type and follow up action are reviewed and analyzed to identify trends and patterns. In addition, the HCSIS medication occurrence data base includes detailed information as to the factors contributing to a medication occurrence. Review of the management reports enable senior staff and the ABI/MFP/TBI Stakeholder Advisory Committee to identify areas and strategies that may lead to a reduction in the number of medication occurrences, a target for service improvement. Information is then shared through training, publication of newsletters and advisories aimed at steps providers can take to reduce the number of medication occurrences. Data is also aggregated on an annual basis and incorporated into the DDS Quality Assurance Briefs, which are reviewed by the statewide quality council for purposes of service improvement targets.

Quality Improvement: Health and Welfare

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. **Methods for Discovery: Health and Welfare**

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The state, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-assurances:

a. Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

***i.* Performance Measures**

For each performance measure the state will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	% of deaths that are required to have a clinical review that received a clinical review. (Number of deaths that have a clinical review/ Total number of deaths required to have a clinical review)
Data Source *(Select one) (Several options are listed in the on-line application): other*	
If 'Other' is selected, specify: mortality review	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	
		☑ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	

				☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☑ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	% of medication occurrences. (Number of medication occurrences report/ Number of medication doses administered)
Data Source *(Select one) (Several options are listed in the on-line application): Medication administration data reports, logs*	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☑ *Annually*	95%, margin of error +/-5%
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	

				☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☑ *Quarterly*
☐ *Other Specify:*	☐ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	% of participants receiving services ~~subject to licensure and certification~~ who ~~know how~~have been trained to report abuse and/or neglect. (Number of participants receiving services ~~subject to licensure and certification~~ who ~~know how~~have been trained to report abuse and neglect/ Number of individuals reviewed)
Data Source *(Select one) (Several options are listed in the on-line application):* *Human Rights Coordinators' Training Record*	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☑ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☑ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	95%, margin of error +/-5%, 50% response distribution (will be adjusted based on performance)
		☑ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☑ *Annually*

	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	% of intakes screened in for investigation of abuse where the need for protective services was reviewed as recommended. (Number of intakes screened in for investigation of abuse where the need for protective services was reviewed/ Total number of intakes where a review for protective services was recommended by the senior investigator)
Data Source *(Select one) (Several options are listed in the on-line application): other*	
If 'Other' is selected, specify: HCSIS Investigations database	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	
		☑ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☑ *Annually*

	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	% of providers who conduct CORI's of prospective employees and take appropriate action when necessary. (Number of providers that conduct CORI's of prospective employees and take required action/ Total number of providers reviewed)

Data Source *(Select one) (Several options are listed in the on-line application): provider performance monitoring*

If 'Other' is selected, specify:

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☑ *Other Specify:*	☐ *Annually*	
	Administrative Services Organization	☑ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☑ *Annually*

	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	No. and rate of substantiated investigations by type. (Number of substantiated investigations by type/ Number of total adults served and rate per 100 adults)

Data Source *(Select one) (Several options are listed in the on-line application): other*

If 'Other' is selected, specify: HCSIS Investigations database

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	
	Administrative Services Organization	☑ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☑ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other*

	Specify:

Performance Measure:	% of providers, subject to DDS licensure and certification, that report abuse and neglect as mandated. (Number of provider agencies that report abuse and neglect as mandated/ Number of providers reviewed)

Data Source *(Select one) (Several options are listed in the on-line application): provider performance monitoring*

If 'Other' is selected, specify:

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	
	Administrative Services Organization	☑ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☑ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

b. Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	% of incident "trigger" reports that have had follow up action taken. (Number of incidents that reach the "trigger" threshold for which action has been taken/ Total number of incidents that reach the "trigger" threshold)
Data Source *(Select one) (Several options are listed in the on-line application): critical events and incidents reports*	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☑ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☑ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	uses a 90% confidence interval and a range of +/- 10% with a finite population correction for the population enrolled in the waiver. ~~90%,~~

				~~margin of error +/- 5%~~
		☑ *Continuously and Ongoing*		☐ *Stratified: Describe Group:*
		☐ *Other Specify:*		
				☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☑ *Quarterly*
☐ *Other Specify:*	☐ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	% of action/safety plans implemented. (number of action/safety plans implemented for substantiated investigations/ Number of action/safety plans written)
Data Source *(Select one) (Several options are listed in the on-line application): other*	
If 'Other' is selected, specify: HCSIS Investigations database	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	

		☑ *Continuously and Ongoing*		☐ *Stratified: Describe Group:*
		☐ *Other Specify:*		
				☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☑ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

c. Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	% of providers that are in compliance with requirements concerning restrictive interventions. (Number of providers that are in compliance with requirements concerning restrictive interventions/ Number of providers reviewed by survey and certification with restrictive interventions)
Data Source *(Select one) (Several options are listed in the on-line application): provider performance monitoring*	

If 'Other' is selected, specify:			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	
		☑ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☑ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	% of providers that are in compliance with requirements concerning unauthorized use of restraints. (Number of providers that are in compliance with requirements concerning unauthorized use of restraints/ Number of providers reviewed by survey and certification)
Data Source *(Select one) (Several options are listed in the on-line application): provider performance monitoring*	

If 'Other' is selected, specify:			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	
		☑ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☑ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

d. Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	% of individuals who have had an annual dental visit in the last 15 months. (Number of individuals with a documented dental visit in the past 15 months/ Number of individuals reviewed)
Data Source *(Select one) (Several options are listed in the on-line application): other*	
If 'Other' is selected, specify: ~~*Provider Performance Monitoring*~~ *HCSIS Health Care Record*	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☑ ~~☐~~ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ ~~☑~~ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	~~*95%, margin of error +/- 5%*~~
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*

☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☑ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	% of individuals who have had an annual physician visit in the last 15 months. (Number of individuals with a documented physician visit in the past 15 months/ Number of individuals reviewed)
Data Source *(Select one) (Several options are listed in the on-line application): other*	
If 'Other' is selected, specify: ~~Provider Performance Monitoring~~ HCSIS Health Care Record	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☑ ~~☐~~ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ ☑ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☑ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	~~95%, margin of error +/- 5%~~
		☑ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other*	☑ *Annually*

Specify:	
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	% of providers who are in compliance with individuals' physicians' orders and treatment protocols being followed. (Number of ~~individuals~~ providers ~~for~~ who~~m~~ demonstrate that an individual's treatment protocol/physicians' orders are being followed/ Number of ~~individuals~~ providers being reviewed by survey and certification~~with treatment protocols/physicians' orders~~)

Data Source *(Select one) (Several options are listed in the on-line application):Provider Performance Monitoring*

If 'Other' is selected, specify:

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☑ ~~☐~~ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ ~~☑~~ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ ~~☑~~ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	~~95%, margin of error +/- 5%~~
		☑ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*

☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☑ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

The Department of Developmental Services (DDS) and MassHealth are responsible for ensuring effective oversight of the waiver program, including administrative and operational functions performed by the Level of Care entity and the Administrative Service Organization. As problems are discovered with the management of the waiver program, the Administrative Services Organization, or waiver service providers, MassHealth/DDS will ensure that a corrective action plan is created, approved, and implemented within appropriate timelines. Timelines for remediation will be dependent on the nature and severity of the issue to be addressed. Further, MassHealth is responsible for identifying and analyzing trends related to the operation of the waiver and determining strategies to address quality- related issues.

ii. **Remediation Data Aggregation**

	Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies)*
	☑ **State Medicaid Agency**	☐ **Weekly**
	☐ **Operating Agency**	☐ **Monthly**
	☐ **Sub-State Entity**	☐ **Quarterly**

	☐ **Other** Specify:	☑ **Annually**
		☐ **Continuously and Ongoing**
		☐ **Other** Specify:

c. **Timelines**

When the state does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

☑	**No**
○	**Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The remediation activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

H.1 Systems Improvement

a. **System Improvements**

i. Describe the process(es) for trending, prioritizing and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

MassHealth's (the Medicaid Agency) quality management strategy is designed to assure that essential safeguards are met with respect to health, safety and quality of life for waiver participants. While there are multiple approaches in place that comprise a robust system, the overall quality management and improvement system continues to evolve and improve. MassHealth has put in place an overarching approach and plan for quality management and improvement across Massachusetts' home and community based services waivers. This plan ensures that the state is able to stratify information to relate to each specific waiver program it operates. The strategy is based on the following key operational principles:

1. The system is designed to create a continuous loop of quality assessment and initiation of improvement including the identification of issues, notification to concerned parties, remediation, follow-up analysis of patterns and trends, and improvement activities.

2. Quality is measured based upon a set of outcome measures agreed upon by waiver stakeholders, which are based on the fundamental purposes of the waiver, CMS assurances, Massachusetts' regulations, and quality goals.

3. The system also assesses quality by measuring health and safety for participants and places a strong emphasis on other quality of life indicators including participant access, person-centered planning and service delivery, rights and responsibilities, community inclusions, participant satisfaction and participant involvement.

Three Tiers of Quality Management

The Quality Management and Improvement System approaches quality from three perspectives: the individual, the provider and the system. On each tier the focus is on the discovery of issues, remediation of identified issues, and system improvement. MassHealth in collaboration with the Massachusetts Rehabilitation Commission (MRC) and the Department of Developmental Services (DDS) have oversight responsibility for all aspects of the Waiver Quality Management and Improvement System for this waiver and the Moving Forward Plan – Residential Supports Waiver, Acquired Brain Injury Residential Habilitation Waiver and the Acquired Brain Injury Non-Residential Habilitation Waiver. Specific areas of oversight include: Level of Care Determination, Service Plans, Qualified Providers, Health and Welfare, Administrative Authority, and Financial Accountability to ensure that direct service providers, the contracted LOC entity, contracted ASO entity and Case Managers are in compliance with applicable standards, policies and procedures.

Systems level improvement efforts are organizationally structured to occur on multiple levels within DDS and MRC. The DDS Office of Quality Management maintains overall responsibility for designing and overseeing the waiver's QMIS and assuring that appropriate data are collected, disseminated, and reviewed, and that service improvement targets are established for participants in these Waivers. The DDS Assistant Commissioner for Quality Management reports in a direct line to the Commissioner, in order to maintain independence from the Operational Services Division.

DDS has an organizational structure of 23 Area Offices and 4 Regional Offices. Case Managers for this waiver are based in the Regional Offices and can draw from staffing and expertise available at both the Area and Regional level. Each Regional Office is overseen by a Regional Director under whose direct supervision the Area Directors function. It is ultimately the Regional Directors, who report directly to the Deputy Commissioner, who are accountable for assuring that identified service improvement efforts are implemented and reviewed.

DDS works collaboratively with MRC to obtain and aggregate data from all sources including providers, the level of care entity and the ASO and make available system-wide data, analysis of such data, and reports to OOM in order to facilitate the discovery, remediation planning and overall system quality improvement strategies.

Processes for trending, prioritizing and implementing system improvements

Tier I: The Individual Level

DDS maintains a number of databases that enable it to collect information on important outcomes pertaining to individuals, providers and overall systems, to review patterns and trends and establish service improvement targets.

On an individual level, the Home and Community Services Information System (HCSIS) previously described in Appendix G, collects information regarding incidents, medication occurrences, investigations and deaths. This is a web-based system that has been in use by DDS since 2006 and has been adapted to incorporate incident types specific to individuals in this Waiver. The HCSIS system includes a Service Coordinator Supervisor Tool which collects aggregate information regarding the development, implementation and oversight of the service planning process and development of the POC through the review of a sample of individuals and their plans.

In addition, DDS utilizes data and reports available through various sources, including the Meditech database and data from the LOC entity that provides both individual and aggregate information regarding eligibility determinations, level of care determinations and re-determinations.

Tier II-The Provider Level

The next level of the Medicaid Agency's quality management and information system relates to ensuring, on an ongoing basis, that providers are qualified and are performing effectively. Providers of Home Accessibility Adaptations and Vehicle Modifications are credentialed, recredentialed, and overseen by MRC. Residential Habilitation and 24 hour Shared Living providers are licensed and certified by DDS. For all other waiver services described in Appendix C providers are credentialed and recredentialed by the ASO. Aggregate data from these processes are collected, reviewed, and analyzed to determine whether there are any patterns or trends that merit the establishment of service improvement initiatives.

Tier III- The System Level

With the current complement of HCBS waivers in Massachusetts, processes have been and continue to be established to support and enhance quality oversight. MassHealth, MRC and DDS are working to ensure that the quality management strategies and infrastructure implemented for the operation of this waiver are consistent with those related to the other HCBS waivers.

MassHealth, MRC and DDS review and evaluate measures related to provider capacity and capability; provider qualifications, performance and compliance with applicable standards and requirements;

safeguards/critical incident management; client satisfaction; and system performance and wherever appropriate align applicable performance measures with those in other waivers. Data gathered from all sources and processes previously noted are analyzed and reviewed by a variety of stakeholders and through a variety of committees. The goal of these processes is to assure that both internal and external stakeholders review essential aggregate data on an ongoing basis in order to improve services and supports for all Waiver participants.

As a starting point, DDS, MRC and MassHealth are committed to assuring the ongoing integrity of data obtained through various collection mechanisms. There are several groups that oversee the standards and quality related to ~~Two major standards groups exist to oversee~~ the Meditech database and HCSIS. These groups function to continually review and agree upon the business processes as well as the definitions and interpretations that guide the system in order to ensure data integrity and consistency.

~~A Statewide Incident Review Committee (SIRC)~~A Statewide Systemic Risk Review Committee (SRRC) composed of staff from DDS Operations, Investigations, human rights, survey and certification, risk management and health services meet~~s~~ regularly to review aggregate data generated from HCSIS. With research support of the University of Massachusetts Medical School/Center for Developmental Disabilities Evaluation and Research (CDDER), aggregate reports analyzing specific incident types are generated. The reports are based on queries that ~~SIRC~~ SRRC determines helpful in analyzing the data. The reports are reviewed by ~~SIRC~~ SRRC and form the basis for identifying patterns and trends that may lead to specific service improvement targets. Examples of service improvement targets directly related to analysis of HCSIS data include, but are not limited to, a major falls prevention initiative, and an initiative to reduce medication occurrences. The ~~SIRC~~ SRRC membership and purview is expanded, as needed, to include the review and analysis of data related to participants in this waiver.

~~In addition, since 2008~~Currently, Area, Region and Provider specific aggregate data on incidents are disseminated ~~quarterly (for frequently occurring incidents)~~annually. These reports show data on incidents by both number and rate that enables comparison between Areas, Regions and the State. Case Managers and Areas also receive monthly reports on individuals who have reached a threshold of specifically designated incidents that then trigger a review by the Case Manager. These reports enable Areas and Regions to identify patterns and trends with respect to particular individuals they support and to "connect the dots" between different incidents. Areas review the reports to assure that all necessary follow up steps have been taken. As part of the on-going quality assurance process, Regional Risk Managers do a quarterly review of a random sample of individuals who have reached the "trigger" threshold. The review looks into whether appropriate follow up actions were taken consistent with the issues identified. This process includes individuals in this waiver.

DDS and MassHealth also analyze death reports and mortality reviews within waivers and across waivers, related to ~~publishes an Annual Mortality Report which details~~ the number of deaths, the age, gender, residential status and cause of death of individuals served by ~~DDS~~these waivers~~; information on individuals in this Waiver is published in a similar report.~~ The results of ~~this report will~~ these analyses enable DDS and MassHealth to determine whether there are any patterns and trends, particularly with respect to preventable deaths.

As an important component of its commitment to stakeholder and participant input, MRC established an ABI, MFP, TBI Waiver Stakeholder Advisory Committee to obtain valuable input from constituents. This committee currently consists of representatives including ABI, MFP and TBI waiver participants, ABI, MFP and TBI case managers, provider agencies, participant family members and individuals with brain injuries. ~~DDS and MRC are using this Committee and have expanded both the focus and the membership of this Advisory Committee to include the MFP Waivers.~~ The committee plays an advisory role and assists in evaluating waiver program performance. Specifically, it reviews data and reports generated

from the previously mentioned data systems, e.g. HCSIS, Death Reporting and provider credentialing, to determine whether any service improvement projects should be initiated.

Finally, DDS has a variety of publications that are disseminated widely to DDS staff, provider staff, individuals and families that provide important information derived from all of the existing data systems. The information is presented in ~~easy~~ easy-~~to~~ to-read formats and in many cases provides "actionable" recommendations to improve health and safety and quality of life for Waiver participants. These publications include the "Quality is no Accident" Brief, the "Living Well Newsletter", Quality Assurance Briefs on specific subject areas, and on-going advisories to the field. These publications have been expanded, as appropriate, to include data for providers, DDS staff and other stakeholders regarding both MFP and ABI Waiver participants.

We have consolidated the reporting for this waiver with ABI Non-Residential Habilitation (MA.40702) (see H.1.b.ii).

ii. System Improvement Activities

Responsible Party *(check each that applies):*	**Frequency of monitoring and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. **System Design Changes**

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

MassHealth, DDS and MRC have a strong commitment to a quality management system which continuously evaluates the processes in place to monitor waiver activities and participant outcomes. As this Waiver created a new mechanism to provide HCBS to a population that previously was largely not able to access these services through publicly-funded programs, MassHealth, MRC and DDS have the opportunity to put in place best practices experienced in other HCBS waivers. The cornerstone of this quality management system is the collaboration among MassHealth, DDS and MRC.

A goal of the waiver quality management system is to obtain concrete discovery data which, when aggregated and analyzed, allows for identification of any assurance areas which need immediate quality improvement strategies to remedy the findings The DDS Office of Quality Management, has primary responsibility for monitoring the effectiveness of system design changes. Implementation of strategies to meet service improvement targets can occur on a variety of levels depending upon the nature of the target. Senior Staff from DDS review and evaluate the effectiveness of service improvement targets and system design changes on an ongoing basis. In addition, previously mentioned groups, notably, the ~~Statewide~~

~~Incident Review Committee~~Systemic Risk Review Committee and the ABI/MFP/TBI Stakeholder Advisory Committee review progress towards achieving targets and making mid-course corrections, if necessary.

Reviews of the effectiveness of service improvement targets are also conducted by CDDER. As an independent research and policy support to DDS, CDDER has conducted several formative and summative evaluations of specific initiatives. Methods have included focus groups, surveys and evaluation of specific indicators related to the service improvement target.

MassHealth, DDS and MRC are committed to working with stakeholders, including participants, to ensure an effective quality management strategy for the Waiver program which utilizes participant-focused quality indicators. The ABI/MFP/TBI Waiver Stakeholder Advisory Committee meets ~~on no less than a quarterly basis~~twice a year and reviews performance, system design changes and assessments. This Committee reviews quality management data as well as other aspects of the quality management strategy for the Waiver program to identify and support the ways MassHealth, DDS and MRC can assess and ensure for the highest quality services. Other meetings with stakeholders (i.e., providers, advocates and families) are conducted on an ad-hoc basis throughout the year. Stakeholder involvement and communication are welcomed and encouraged through the formal Committee as well as ad-hoc meetings.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

In collaboration with MassHealth, MRC and DDS are committed to evaluating the processes and systems in place which comprise our quality management strategy.

The Office of Quality Management within DDS in close collaboration with MRC has primary day to day responsibility for assuring that there is an effective and robust quality management system. DDS and MRC work closely with internal and external stakeholders and make recommendations regarding enhancements to the QMIS system on an ongoing basis.

DDS and MRC continue to work with CDDER to evaluate the effectiveness of its QMIS system and to make recommendations for improvements.

As part of the evaluation of the Quality Improvement Strategy, MassHealth, DDS and MRC we analyzed reporting across several waivers and, and as noted above, consolidated the reporting for the ABI Non-Residential Habilitation (MA.40702) and MFP Community Living (MA.1027) Waivers. Our ongoing evaluation supports the determination that because these waivers continue to utilize the same quality management and improvement system, that is, they are monitored in the same way, and discovery, remediation and improvement activities are the same, these waivers continue to meet the CMS conditions for a consolidated evidence report. Specifically, the following conditions are present:
1. The design of these waivers is very similar as determined by the ~~similarity~~ alignment in participant services ~~(very similar)~~, participant safeguards ~~(the same)~~ and quality management ~~(the same)~~;
2. The quality management approach is the same across these two waivers including:
a. methodology for discovering information with the same HCSIS system and sample selection,
b. remediation methods,
c. pattern/trend analysis process, and
d. all of the same performance indicators;
3. The provider network is the same; and
4. Provider oversight is the same.

For performance measures based on sampling the sample size unless noted differently will be based on a simple random sample of the combined populations with a confidence level of- a 95% confidence level and a +/-5% margin of error 95/5 response distribution.~~.95.~~

All measures, methodologies and data systems are fully aligned.

The ABI Non-Residential Habilitation (MA.40702) and MFP Community Living (MA.1027) Waivers operate on similar waiver cycles with only one month difference between the effective dates for these waivers. The combined evidence report will be based on the schedule for the MFP Community Living Waiver (MA.1027). Because the state has moved the reporting up by one month for MA.40702 (one month earlier), there is no loss of data.

H.2 Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one):*

- No
- Yes *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- HCBS CAHPS Survey;
- NCI Survey;
- NCI AD Survey;
- Other *(Please provide a description of the survey tool used)*:

Appendix I: Financial Accountability

APPENDIX I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

(a)MassHealth engages an Administrative Service Organization (ASO) to recruit qualified direct service providers who are in good financial standing for all waiver services except those qualified and contracted for by MRC. The waiver services for which providers are qualified/contracted by MRC include Home Accessibility Adaptations, Transitional Assistance Services and Vehicle Modifications. All direct service providers execute MassHealth Provider Agreements. As part of the Single State Audit, ~~KPMG~~ the auditor reviews samples of waiver claims and activity, as noted below. Waiver service providers must comply with audit requirements specified in 808 CMR 1.00: Compliance, Reporting and Auditing for Human and Social Services. In addition, the ASO is required to have an annual independent audit.

(b) The integrity of provider billing data for Medicaid payment of waiver services is managed by the Massachusetts Medicaid Management Information System (MMIS). MassHealth confirms the delivery of services, the units of services and the cost of all services through contract and invoice management prior to submitting claims to Medicaid. MassHealth establishes rates for each waiver service. MMIS sets payment ceilings to ensure integrity of payment and also confirms each participant's Medicaid waiver eligibility as a condition of payment.

(c) The Executive Office of Health and Human Services is responsible for conducting the financial audit program.

The MassHealth Program Integrity Unit oversees rigorous post payment review processes that identify claims that are paid improperly due to fraud, waste and abuse. MassHealth maintains an interdepartmental service agreement with the University of Massachusetts Medical School's Center for Health Care Financing to carry out post-payment review and recovery activities through its Provider Compliance Unit (PCU). MassHealth maintains consistent post-payment review methods, scope, and frequency for self-direction and agency providers.

On a regular basis, PCU runs Surveillance Utilization Review System (SURS) reports to identify aberrant billing practices. MassHealth runs SURS reports and algorithms that examine all provider types such that every provider type is generally being reviewed with a SURS report each year. For example, MassHealth and the PCU run a recurring algorithm that identifies any claims paid for members after their date of death as well as a report that identifies outliers in billing growth by provider type and reports that identify excessive activity, e.g., unusually high diagnosis and procedure code frequencies, by provider as well as “spike” reports that identify providers receiving higher than average payments. On average, MassHealth runs between 30 and 40 algorithms per year and 100 to 120 SURS reports of varying scope (e.g. all provider types, specific provider types, or a single provider) per year. These SURS reports and algorithms are run manually and not on a set

schedule. There are no set criteria that must be met prior to MassHealth running particular SURS reports and algorithms.

When MassHealth identifies outliers in SURS reports or algorithms, additional SURS reports or algorithms may be run that are focused on that provider type identifying specific providers with unusual patterns or aberrant practices to enable targeting for additional review, including desk review or on-site audit. Desk reviews and audits are not solely initiated following findings in SURS reports and algorithms and may also be initiated due to a member complaint or a concern raised by the MassHealth program staff.

In addition, MassHealth and PCU regularly develop algorithms that identify duplicative or noncompliant claims for recovery. MassHealth regularly reviews algorithm and SURS report results to identify providers with a large number of noncompliant claims, aberrant billing patterns or excessive billings. Upon discovering such providers, MassHealth and PCU will open desk reviews or on-site audits targeting the provider. The scope and sampling methodology of post-payment reviews will vary from case to case. Algorithms and SURS reports typically review 100% of claims received for a given provider type over a specified timeframe. The sampling process for post-payment review (desk review and on-site audits) entails generating a random sample of all members receiving services over the audit review period. For audits and desk reviews, MassHealth and PCU will perform a random sample of members at a 90% confidence level and review all claims and associated medical records for each member over a specified timeframe (typically 4 to 6 months). A margin of error is calculated and determined only for reviews and audits in which MassHealth intends to extrapolate overpayments based on the findings from the review or audit to the provider's full census. Where extrapolation may be performed, MassHealth and PCU typically pull a sample of 25 members and use the lower 90% confidence interval amount as the extrapolated overpayment amount to be recouped. The margin of error for the extrapolated amount can vary depending upon the total number of members the provider has served during the audit period. Where the provider has served fewer than 25 members over the audit period, MassHealth and PCU will review all of the members and associated claims resulting in a margin of error of +/- 0%.

On average, MassHealth and PCU run between 30 and 40 algorithms and SURS reports to identify recoveries as well as target providers for desk reviews and on-site audits. Because SURS reports and algorithms do not always identify providers exhibiting aberrant billing behavior, and because member complaints or program staff concerns are raised on an ad hoc basis, there is no scheduled number of desk reviews or on-site audits to be conducted on a year-to-year basis. When MassHealth identifies findings through SURS reports and algorithms, it is MassHealth practice to conduct a desk review or on-site audit within one month.

As part of its post-payment review activities, MassHealth and PCU regularly carry out desk reviews and on-site audits of providers. When initiating a provider desk review, auditors will request medical records, including individualized plans of care, for a sample of MassHealth members receiving services from the provider and compare them against claims data to ensure all paid claims are supported by accurate and complete documentation. As part of on-site audits, MassHealth and PCU develop an audit scope document that identifies specific regulatory requirements to be reviewed. Based on this scope, PCU will develop an audit tool to record the auditors' findings related to compliance or noncompliance of each regulatory requirement being reviewed. During their on-site visit, auditors will collect medical records for a sample of members to review for completeness and accuracy. Finally, to verify that services were rendered, auditors will visit a random sample of member homes, interview the members, and observe living conditions to ensure services are rendered consistently with each member's plan of care. The sampling process for home visits is to select a random sample of three to five members. MassHealth and PCU select a smaller sample size for home

visits than for desk reviews due to the logistics of conducting on-site audits within a two to three day timeframe.

Upon completion of an on-site audit or desk review, MassHealth will review the findings of noncompliance, if any, with regulatory requirements and determine whether to issue a notice of overpayment or sanction to the provider, depending on whether the provider was found in violation of applicable regulatory requirements. The notice of overpayment or sanction identifies and explains each instance of noncompliance, and notifies the provider of the associated sanctions and identifies the related overpayments. Within the notice, the provider receives the detailed results of the audit review, including lists of each regulatory requirement, the description of the provider's noncompliance, and the associated sanction or overpayment amount. On a case-by-case basis, MassHealth may meet with the provider to review the audit findings and discuss the appropriate corrective actions.

Providers have the opportunity to appeal MassHealth's determination of sanction or overpayment and dispute the related findings. While the appeal is processed, MassHealth will withhold the identified amount of identified overpayments or impose sanctions of administrative fines from future payments to the provider. If the sanctions or overpayment determinations are not appealed, MassHealth will work with the provider to establish a payment plan where a percentage of the overpayment amount is withheld from future payments of the provider's claims until the entire balance of the overpayment or sanction of administrative fines have been recouped.

As a result of a desk review or on-site audit, MassHealth may also require the provider to submit a plan of correction and may identify the provider to be re-audited after a specified period of time (e.g., 6 months) to ensure corrections are made.

Unlike desk reviews and on-site audits where reviewers are manually reviewing claims for a sample of members over a four to six month time period, algorithms and SURS reports generally look back over a longer timeframe up to five years for all claims associated with one or more provider types.

In addition to the activities described above, MassHealth maintains close contact with the attorney general's Medicaid Fraud Division (MFD) to refer potentially fraudulent providers for MFD review and to ensure MassHealth is not pursuing providers under MFD's review.

~~KPMG is the contractor that performs the Single State Audit for the Commonwealth of Massachusetts.~~

Quality Improvement: Financial Accountability

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. **Methods for Discovery: Financial Accountability Assurance**
The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions*

submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-assurances:

a Sub-assurance: The state provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

a.i. Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	Service claims are coded and paid for in accordance with the specified reimbursement methodology and only for services rendered. % of claims for services with the Financial Management Service (FMS) that are filed appropriately. (Approved claims filed with the FMS/ Total number of claims filed with the FMS)
Data Source *(Select one) (Several options are listed in the on-line application):* Financial records (including expenditures)	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☑ *Annually*	

		☐ *Continuously and Ongoing*		☐ *Stratified: Describe Group:*
		☐ *Other Specify:*		
				☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☑ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	Service claims are coded and paid for in accordance with the specified reimbursement methodology and only for services rendered. % of claims submitted to and paid by MMIS will be monitored and reported to MassHealth and DDS by the ASO using remittance advices. (Approved and paid MMIS claims/ Total service claims submitted)
Data Source *(Select one) (Several options are listed in the on-line application):* Financial records (including expenditures)	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other*	☑ *Annually*	

	Specify:			
		☐ *Continuously and Ongoing*		☐ *Stratified: Describe Group:*
		☐ *Other Specify:*		
				☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☑ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	Services are coded and paid for in accordance with the reimbursement methodology. (Number of services with rates derived from and consistent with rate regulations/ Number of services for which claims were submitted)

Data Source *(Select one) (Several options are listed in the on-line application):* Financial records (including expenditures)
If 'Other' is selected, specify:

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☑ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☑ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The Administrative Service Organization reviews all claims prior to submission. The ASO will submit quarterly reports to DDS. Data are aggregated and analyzed annually to ensure services are billed in accordance with established waiver service payment rates.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

DDS is responsible for ensuring that provider billing is in accordance with the services authorized in the service plan. The Administrative Service Organization (ASO) will ensure that services are billed in accordance with the established rate for the service provided. If any discrepancy is noted the ASO will report the error to MassHealth and/or DDS and/or service provider and the services will only be claimed upon reconciliation of the discrepancy. Claims that cannot be reconciled with payment vouchers or other service documentation will be reported to DDS and will be denied.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	***Responsible Party*** *(check each that applies)*	***Frequency of data aggregation and analysis:*** *(check each that applies)*
	☑ **State Medicaid Agency**	☐ **Weekly**
	☐ **Operating Agency**	☐ **Monthly**
	☐ **Sub-State Entity**	☐ **Quarterly**
	☐ **Other** Specify:	☑ **Annually**
		☐ **Continuously and Ongoing**
		☐ **Other** Specify:

c. **Timelines**

When the state does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

☑	**No**
○	**Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

APPENDIX I-2: Rates, Billing and Claims

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

EOHHS is required by state law to develop rates for health services purchased by state governmental units, and which includes rates for waiver services purchased under this waiver. State law further requires that rates established by EOHHS for health services must be "adequate to meet the costs incurred by efficiently and economically operated facilities providing care and services in conformity with applicable state and federal laws and regulations and quality and safety standards and which are within the financial capacity of the commonwealth." See MGL Chapter 118E Section 13C. This statutory rate adequacy mandate guides the development of all rates described herein.

In establishing rates for health services, EOHHS is required by statute to complete a public process that includes issuance of a notice of the proposed rates with an opportunity for the public to provide written comment, and EOHHS is required to hold public hearing to provide an opportunity for the public to provide oral comment. See MGL Chapter 118E Section 13D; see also MGL Chapter 30A Section 2. The purpose of this public process is to ensure that the public (and in particular, providers) are given advance notice of proposed rates and the opportunity to provide feedback, both orally and in writing, to ensure that proposed rates meet the statutory rate adequacy requirements noted above.

All rates established in regulation by EOHHS are required by statute to be reviewed biennially and updated as applicable, to ensure that they continue to meet the statutory rate adequacy requirements. See MGL Chapter 118E Section 13D. The HCBS rate regulation was last updated effective ~~January 1, 2017~~April 1, 2021. In updating rates to ensure continued compliance with statutory rate adequacy requirements, a cost adjustment factor (CAF) or other updates to the rate models may be applied.

The rates for all waiver services in this waiver were established in accordance with the above statutory requirements. Additional information on the rate development for each waiver service follows.

The ~~MFP~~ waiver rates can be found in EOHHS ~~MFP~~ waiver services regulations 101 CMR 359.00 (Rates for Home and Community Based Services Waivers). The regulation can be found on the MassHealth website: www.mass.gov/eohhs/gov/departments/masshealth/ 101 CMR 359.00 establishes rates for waiver services based on and tied to existing rate setting methodologies for similar/same services when possible. As such, the rates for waiver services in this waiver are established in one of four ways, as follows:

1. For waiver services in which there is a comparable Medicaid state plan rate, the waiver service rate was established in regulation at the comparable Medicaid state plan rate after public hearing pursuant to MGL Chapter 118E, Section 13D. All Medicaid state plan rates were established in regulation pursuant to this same statutory requirement. Medicaid State Plan rates are developed using provider cost data submitted to the Center for Health Information and Analysis (CHIA) in

accordance with provider cost reporting requirements under 957 CMR 6.00: Cost Reporting Requirements. The provider cost data is used to calculate rates that meet the statutory rate adequacy requirements noted above. There are no differences in the rate methodology between these state plan and waiver services. No additional CAF was used for the waiver services using the comparable state plan rate. This applies to the following waiver services:

Skilled Nursing (~~set in accordance with 114.3~~101 CMR 350.00 Home Health Services; Rates for Skilled Nursing Services)

Occupational, Physical and Speech Therapy (~~set in accordance with~~ 101~~114.3~~ CMR 350.00: Rates for Home Health Services for agency services and 101~~114.3~~ CMR 339.00 Rates for Restorative~~Rehabilitation Center~~ Services out-of-office visit rates for Individual Providers)

Specialized Medical Equipment (~~set in accordance with~~ 101~~114,3~~ CMR 322.00: Durable Medical Equipment, Oxygen and Respiratory Therapy Equipment)

Transportation (~~set in accordance with~~ 101~~114.3~~ CMR 327.00 Ambulance and Wheelchair Van Services)

2. For waiver services where there is a comparable EOHHS Purchase of Service (POS) rate, the waiver service rate was established in regulation at the comparable POS rate after public hearing pursuant to MGL Chapter 118E, Section 13D. All POS rates were established in regulation pursuant to this statutory requirement. POS rates are developed using Uniform Financial Reporting (UFR) data submitted to the Massachusetts Operational Services Division, in accordance with UFR reporting requirements under 808 CMR 1.00: Compliance, Reporting and Auditing for Human and Social Services. EOHHS uses UFR data to calculate rates that meet statutory adequacy requirements described above. No productivity expectations and administrative ceiling calculations were used in establishing these rates. UFR data demonstrates expenses of providers of a particular service for particular line items. Specifically, UFRs include line items such as staff salaries; tax and fringe benefits; expenses such as training, occupancy, supplies and materials, or other expenses specific to each service; and administrative allocation. EOHHS uses these line items from UFRs submitted by providers as components in the buildup for the rates for particular services by determining the average for each line item across all providers. In determining the rates for the services noted below~~Residential Habilitation, Shared Living – 24 Hour Supports, Residential Family Training, Individual Support and Community Habilitation, and Peer Support~~, EOHHS used the most recent complete state fiscal year UFR available and determined the average across providers of that service for each line item, which are then used to build each rate.

The waiver service rate is set at the comparable EOHHS POS rate for the following waiver services:
Residential Family Training ~~(set in accordance with~~ 101 CMR 414.00: Rates for Family Stabilization Services; Family Training rate)

Individual Support and Community Habilitation (~~set in accordance with~~ 101 CMR 423.00: Rates for Certain In-Home Basic Living Supports)

Peer Support (~~set in accordance with~~ 101 CMR 414.00: Rates for Family Stabilization Services)

Residential Habilitation (~~set in accordance with~~ 101 CMR 420.00 Rates for Adult Long-Term Residential Services)

Shared Living – 24 Hour Supports (~~set in accordance with~~ 101 CMR 411.00 Rates for Certain Placement~~, and~~ Support and Shared Living Services)

Community Based Day Supports (~~set in accordance with~~ 101 CMR 415.00: Rates for Community-Based Day Support Services)

Community Behavioral Health Support and Navigation (~~set in accordance with~~ 101 CMR ~~423~~444.00: Rates for Certain Substance-Related and Addictive Disorders~~In-Home Basic Living Supports~~)

Supported Employment (101 CMR 419.00: Rates for Supported Employment Services)

Assistive Technology - evaluation and training (101 CMR 423.0**0:** Rates for Certain In-Home Basic Living Supports)

3. For waiver services in which there is no comparable state plan or EOHHS POS rate, a rate for the waiver service was developed and established under 101 CMR 359.00 after public hearing pursuant to MGL Chapter 118E, Section 13D, and as described below.

~~This applies to the following waiver services: Assisted Living, Day Services, Orientation and Mobility Services, Pre-Vocational Services, and Supported Employment~~.

Rates for Assisted Living, Day Services and Prevocational Services set in 101 CMR 359.00 were updated from prior rates by applying a prospective CAF of 2.14%, with a base period of 2020 Q2 and a prospective rate period of 2020 Q3 through 2022 Q2. The CAF is based on the Massachusetts Consumer Price Index for Spring 2019 optimistic forecast provided by IHS Markit Economics.

Rates for Orientation and Mobility services set in 101 CMR 359.00 were updated using calendar year (CY) 2019 Medicare Resource-Based Relative Value Scale system, which calculates service rates by multiplying the CY2019 Medicare conversion factor, a standard dollar value, by the Medicare-assigned relative value units for the service.

~~Rates for Assisted Living were developed from the previously effective MFP Waiver rate regulation at 101 CMR 357.00. The historic rates were based on existing rates for comparable service components (including personal care, skilled nursing visits, and homemaker, supportive home care aide, and individual support/community habilitation, where applicable), and weighted by projected units per week. The rates remained unchanged based on provider input gathered during the public hearing process for the proposed rate updates to the rates established under 101 CMR 359.00.~~

~~Rates for Day Services were developed using FY2010 contract data for Community Based Day Support Services purchased by the Department of Developmental Services, and remained unchanged from the prior effective rate period based on provider input gathered during the public hearing process for the proposed updates to the rates established under 101 CMR 359.00. The FY2010 contract data for Community Based Day Support Services was based on model budgets for providers of this service, which included line items for staff salaries (including management and direct care staff), tax and fringe benefits, occupancy, other expenses and administrative allocation. The salaries used to impute direct care resources reflect the weighted average for the applicable job titles. The unit cost elements for the other direct program costs are based on the median for the applicable input. The model budget was based on a provider capacity of 15 clients, operating at 90% of this capacity, with a ratio of 1 staff member for every 3 clients.~~

~~Rates for Orientation and Mobility services were based on the historic rate for such services from 101 CMR 356.00: Rates for Money Follows the Person Demonstration Services. The rates remained unchanged based on provider input gathered during the public hearing process for the proposed rate updates to the rates established under 101 CMR 359.00.~~

~~Rates for Prevocational and Supported Employment Services are based on historic rates for such services from the rate regulation 114.4 CMR 10.00: Rates for Competitive Integrated Employment Services. The rates were then updated with a retrospective CAF of 6.86%. Data for the calculation of the CAF came from Global Insights. The CAF is the percent increase between the base period index number (i.e., the listed index value for 2012Q3) and the effective period index number (i.e., the average of the index numbers over the effective period of the rate regulation [2017Q1 through 2018Q4]).~~

4. Assistive Technology - devices, Home Accessibility Adaptations and Transitional Assistance are paid at Individual Consideration (IC). Where IC rates are designated, the appropriate payment rate is determined in accordance with the following standards and criteria established in 101 CMR 359.00:
(a) the amount of time required to complete the service or item;
(b) the degree of skill required to complete the service or item;
(c) the severity or complexity of the service or item;
(d) the lowest price charged or accepted from any payer for the same or similar service or item, including, but not limited to any shelf price, sale price, advertised price, or other price reasonably obtained by a competitive market for the service or item; and
(e) the established rates, policies, procedures, and practices of any other purchasing governmental unit in purchasing the same or similar services or items.

All costs that are not eligible for federal financial participation, such as room and board, are specifically excluded from the rate computation of any waiver services.

The waiver case manager will inform the participant of the availability of information about waiver services payment rates and 101 CMR 359.00.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

The Administrative Service Organization reviews all claims prior to submission, comparing the services billed with the services authorized in the waiver Plan of Care (POC). If any discrepancy is noted the ASO will report the error to DDS and/or the service provider and the services will only be claimed upon reconciliation of the discrepancy. Claims that cannot be reconciled will be reported to DDS. Once reconciled the ASO will submit claims for all services (except Residential Habilitation, Shared Living - 24 Hour Supports, Home Accessibility Adaptations and Transitional Assistance Services) to the MMIS which will process and pay claims as appropriate. Prior to payment, the MMIS system verifies each participant's MassHealth eligibility. Claims payments will be made directly to the waiver service providers.

Payment of provider claims for waiver services are made in accordance with Medicaid timeframes and promptness requirements.

Providers of Residential Habilitation and Shared Living - 24 Hour Supports are reimbursed by DDS on a monthly basis subsequent to the provision of services and upon receipt of an electronic invoice through the Electronic Invoice Management System (EIM). ~~DDS reviews and approves invoices with information from case managers and the Electronic Invoice Management System (EIM) or the Massachusetts Management Accounting and Reporting System (MMARS).~~

Providers of Home Accessibility Adaptations and Transitional Assistance Services are reimbursed by MRC on a monthly basis subsequent to the provision of services and upon receipt of an electronic invoice through EIM. ~~MRC reviews and approves invoices with information from case managers, via the Electronic Invoice Management System (EIM) or the Massachusetts Management Accounting and Reporting System (MMARS).~~

DDS and MRC review and approve invoices with information from case managers and the EIM or the Massachusetts Management Accounting and Reporting System (MMARS).

Residential Habilitation, Shared Living - 24 Hour Supports, Home Accessibility Adaptations and Transitional Assistance Services expenditure reports are then generated and processed, and are submitted to MMIS to determine Federal Financial Participation (FFP) amounts. Claims for Residential Habilitation, Shared Living - 24 Hour Supports, Home Accessibility Adaptations and Transitional Assistance Services are adjudicated through the state's approved MMIS system. Once the claims have been adjudicated through the CMS approved MMIS system, which validates that the claims are eligible for FFP, the expenditures for waiver services are reported on the CMS 64 report. On a routine basis, at a minimum, quarterly, the claim data is electronically submitted to MMIS for claim editing and processing for eligible participants and expenditures.

When a participant chooses one of the Participant Directed Services listed in Appendix E-1, the Participant Directed Service will be included in the participant's Plan of Care (POC). The POC will include the frequency and duration of the authorized Participant Directed Service. The participant will submit their timesheet weekly to the Financial Management Service (FMS) for each worker who provided Participant Directed Services. The FMS will then submit a claim to MMIS for the Participant Directed Service. MMIS will generate payment to the FMS. The FMS will issue appropriate checks in the name of the worker and will mail the check to the MFP waiver participant who will distribute the check to the worker. The worker may elect, as most workers do, to have the FMS direct deposit payment into the worker's bank account in which case, the participant will notify the FMS to do so. ~~In rare cases where the worker does not choose direct deposit, the FMS issues appropriate checks in the name of the worker and mails the check to the waiver participant who then distributes the check to the worker.~~

Providers may bill Medicaid directly. Direct billing instructions are provided upon request.

c. Certifying Public Expenditures *(select one)*:

○	**No. State or local government agencies do not certify expenditures for waiver services.**	
☑	**Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.** *Select at least one:*	
	☑	Certified Public Expenditures (CPE) of State Public Agencies. Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures

		are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-a.*)
		Expenditures for Residential Habilitation, Shared Living - 24 Hour Supports, Transitional Assistance Services and Home Accessibility Adaptations services are funded from annual legislative appropriations to the Executive Office of Health and Human Services. Claims for these services are adjudicated through the state's approved MMIS system. Rates are based on the total costs for and utilization of waiver services. Once the claims have adjudicated through the CMS approved MMIS system, which validates that the claims are eligible for Federal Financial participation, the expenditures for waiver services are reported on the CMS 64 report. MRC is the agency that certifies public expenditures for Home Accessibility Adaptations and Transitional Assistance waiver services. DDS is the agency that certifies public expenditures for Residential Habilitation and Shared Living - 24 Hour Supports waiver services. Expenditures are certified annually utilizing cost report data. The state's contractor from the Public Provider Reimbursement Unit at the University of Massachusetts Medical School (UMMS) Center for Health Care Financing reviews cost reports and identifies allowable costs and disallowable costs (such as room and board). MRC and DDS make payments to private providers with whom they contract. These providers retain 100% of the payment.
	☐	**Certified Public Expenditures (CPE) of Local Government Agencies**. Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The Massachusetts Medicaid Management Information System (MMIS) maintains date specific eligibility on Medicaid waiver participants. Only service claims for participants whose MassHealth waiver eligibility is verified are submitted for payment processing. The case manager will validate that the service was included in and authorized by the participant's approved plan of care, and was, in fact, provided.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.

APPENDIX I-3: Payment

a. Method of payments — MMIS *(select one)*:

☑	**Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
○	**Payments for some, but not all, waiver services are made through an approved MMIS.** Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
○	**Payments for waiver services are not made through an approved MMIS.** Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:
○	**Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.** Describe how payments are made to the managed care entity or entities:

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

☑	**The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
☐	**The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
☑	**The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.** Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:
	For Participant Directed Services, the participant submits timesheets for workers to the Financial Management Service (FMS). The FMS reviews time sheets for participant-directed services, verifies that they are in accordance with the Plan of Care and submits claims to MMIS for payment. The FMS contract includes performance metrics and the submission of monthly reports reconciling expenditures for each participant with their approved service plan. The Medicaid agency conducts an annual monitoring visit to the FMS. The state will implement use of an electronic visit verification (EVV) system for certain services in

	accordance with the 21st Century Cures Act; the FMS will continue to review time sheets, including those submitted through the use of an EVV system.
☐	**Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.** Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

☑	**No**. **The state does not make supplemental or enhanced payments for waiver services.**
○	**Yes**. **The state makes supplemental or enhanced payments for waiver services.** Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

☑	**No**. **State or local government providers do not receive payment for waiver services.** *Do not complete Item I-3-e.*
○	**Yes**. **State or local government providers receive payment for waiver services.** *Complete item I-3-e.* Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish. *Complete item I-3-e.*

e. **Amount of Payment to State or Local Government Providers**.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one*:

○	**The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.**
○	**The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
○	**The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.** Describe the recoupment process:

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

☑	**Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
○	**Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.** Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

☑	**No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
○	**Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).** Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

☑	**No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
○	**Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.** Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified

	providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

☑	**The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
○	**The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.** Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and (d) how payments are made to the health plans.
○	**This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**
○	**This waiver is a part of a concurrent §1115/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1115 waiver specifies the types of health plans that are used and how payments to these plans are made.**

APPENDIX I-4: Non-Federal Matching Funds

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the state source or sources of the non-federal share of computable waiver costs. *Select at least one:*

☑	**Appropriation of State Tax Revenues to the State Medicaid Agency**
☑	**Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.** If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:
	~~Appropriation of State Tax Revenues is made to the Executive Office of Health and Human Services, the single State Medicaid Agency.~~ Expenditures for ~~Residential Habilitation, Shared Living – 24 Hour Supports, Home Accessibility Adaptations, and Transitional Assistance Services~~ all waiver services are funded from annual legislative appropriations to the Executive Office of Health and Human Services (EOHHS), the single State Medicaid Agency. EOHHS then transfers to MRC 100% of the funds for the Home Accessibility Adaptations and Transitional Assistance Services waiver service and transfers to DDS 100% of the funds for the Residential Habilitation and Shared Living – 24 Hour Supports waiver services. Both MRC and DDS are organized under EOHHS and subject to its oversight authority. As indicated in Appendix A-1, each is a separate agency established by and subject to its own enabling legislation. The transfer of funds and requirements for each party are specified in an Interagency Service Agreement (ISA) between EOHHS and MRC and between EOHHS and DDS, respectively. MRC and DDS use the funds to make payments for these services to private providers contracted through either MRC or DDS. These providers retain 100% of the payment. DDS certifies public expenditures for Residential Habilitation and Shared Living – 24 Hour Supports services, and MRC certifies public expenditures for Home Accessibility Adaptations services and Transitional Assistance Services. Expenditures are certified annually utilizing cost report data. The state's contractor from the Public Provider Reimbursement Unit at the University of Massachusetts Medical School (UMMS) Center for Health Care Financing review cost reports and identify allowable and disallowable costs (such as room and board). Claims for these services are adjudicated through the state's approved MMIS system. Rates are based on the total costs for and utilization of waiver services. Once the claims have adjudicated through the CMS approved MMIS system, which validates that the claims are eligible for Federal Financial participation, the expenditures for waiver services are reported on the CMS 64 report.
☐	**Other State Level Source(s) of Funds.** Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select one:*

☑	**Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
○	**Applicable** *Check each that applies:*

☐	**Appropriation of Local Government Revenues.** Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:
☐	**Other Local Government Level Source(s) of Funds.** Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds . *Select one:*

☑	**None of the specified sources of funds contribute to the non-federal share of computable waiver costs.**
○	**The following source(s) are used.** *Check each that applies.*

☐	**Health care-related taxes or fees**
☐	**Provider-related donations**
☐	**Federal funds**
	For each source of funds indicated above, describe the source of the funds in detail:

APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

○	**No services under this waiver are furnished in residential settings other than the private residence of the individual.**
☑	**As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

The Executive Office of Health and Human Services (EOHHS) has developed rates that are used to pay for the service delivered in residential habilitation, assisted living and shared living-24 hour supports settings for participants in this waiver.

EOHHS developed the service rates by examining the Uniform Financial Reports (UFRs) of several current providers of the residential habilitation service. The UFRs detail costs incurred by the providers for particular activities, and clearly separate activity costs that are part of the residential habilitation service from activity costs that related to providing room and board to residents in these settings. Shared Living-24 Hour Supports services and Assisted Living Services rates were developed based on an amalgamation of existing rates for comparable service components and an analysis of provider cost data. All room and board costs are excluded from the rate computation.

For residential habilitation EOHHS developed a separate schedule of rates reflecting the cost of room and board for participants; the Commonwealth will make room and board payments separately from the service rate payments. The Commonwealth makes payments for room and board directly to the providers of residential habilitation service through the state accounting system MMARS. These payments are not submitted to the MMIS system. The Commonwealth's payments to providers for the cost of room and board will not be submitted for Medicaid claims.

Participants receiving Assisted Living Services and Shared Living-24 Hour Supports are responsible for payment of room and board charges directly to the landlord.

APPENDIX I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.
Select one:

☑	**No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
○	**Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.** The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

a. Co-Payment Requirements. Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

☑	**No. The state does not impose a co-payment or similar charge upon participants for waiver services.** (*Do not complete the remaining items; proceed to Item I-7-b*).
○	**Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.** (*Complete the remaining items*)

i. Co-Pay Arrangement

Specify the types of co-pay arrangements that are imposed on waiver participants *(check each that applies)*:

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*	
☐	**Nominal deductible**
☐	**Coinsurance**
☐	**Co-Payment**
☐	**Other charge** *Specify*:

ii Participants Subject to Co-pay Charges for Waiver Services.

Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded

iii. Amount of Co-Pay Charges for Waiver Services. The following table lists the waiver services defined in C-1/C-3 for which a charge is made, the amount of the charge, and the basis for determining the charge.

Waiver Service	Charge	
	Amount	Basis

iv. Cumulative Maximum Charges.

Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant *(select one)*:

○	**There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.**
○	**There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.** Specify the cumulative maximum and the time period to which the maximum applies:

b. Other State Requirement for Cost Sharing. Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

☑	**No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
○	**Yes**. **The state imposes a premium, enrollment fee or similar cost-sharing arrangement.** Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income (c) the groups of participants subject to cost-sharing and the groups who are excluded~~;~~ and (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care *(specify)*:							
Col. 1	**Col. 2**	**Col. 3**	**Col. 4**	**Col. 5**	**Col. 6**	**Col. 7**	**Col. 8**
Year	**Factor D**	**Factor D′**	**Total: D+D′**	**Factor G**	**Factor G′**	**Total: G+G′**	**Difference (Column 7 less Column 4)**
1	~~167657.54~~ 186,175.06	~~25719.01~~ 18,773.11	~~193376.55~~ 204,948.17	~~201047.53~~ 240,643.73	~~10839.12~~ 18,486.26	~~211886.65~~ 259,129.99	~~18510.10~~ 54,181.82
2	~~177059.63~~ 192,215.80	~~27023.74~~ 19,373.85	~~204083.37~~ 211,589.65	~~211246.70~~ 248,344.33	~~11388.99~~ 19,077.82	~~222635.69~~ 267,422.15	~~18552.32~~ 55,832.50
3	~~186138.50~~ 198,491.52	~~28306.23~~ 19,993.81	~~214444.73~~ 218,485.33	~~221272.03~~ 256,291.35	~~11929.49~~ 19,688.31	~~233201.52~~ 275,979.66	~~18756.79~~ 57,494.33
4	~~196829.83~~ 204,919.88	~~29970.18~~ 20,633.62	~~226800.01~~ 225,553.50	~~234279.22~~ 264,492.67	~~12630.75~~ 20,318.33	~~246909.97~~ 284,811.00	~~20109.96~~ 59,257.50
5	~~205219.00~~ 211,568.49	~~31213.73~~ 21,293.89	~~236432.73~~ 232,862.38	~~244000.19~~ 272,956.44	~~13154.84~~ 20,968.52	~~257155.03~~ 293,924.96	~~20722.30~~ 61,062.58

Appendix J-2: Derivation of Estimates

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care: Hospital	Level of Care: Nursing Facility
Year 1	~~364~~ 624	~~184~~ 478	~~180~~ 146
Year 2	~~424~~ 674	~~214~~ 516	~~210~~ 158
Year 3	~~484~~ 724	~~245~~ 554	~~239~~ 170
Year 4 (only appears if applicable based on Item 1-C)	~~529~~ 774	~~267~~ 592	~~262~~ 182
Year 5 (only appears if applicable based on Item 1-C)	~~574~~ 824	~~290~~ 631	~~284~~ 193

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in Item J-2-a.

The average length of stay (ALOS) for each year is based on actual length of stay as reported in the WY 20 CMS 372 report.
~~of the waiver reflects a weighted average of new participants for that waiver year and waiver participants who continue in the waiver from the prior year. Based on experience thus far with the MFP-RS population, new participants are averaged at 179 days; this accounts for people entering the waiver early in the waiver year and later in the waiver year. Waiver participants from the previous waiver year have an average length of stay of 348 days. The average length of stay during the five-year waiver renewal period is as follows: 320 (WY1); 324 (WY2); 327 (WY3); 333 (WY4); 335 (WY5).~~

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

Factor D costs are based on the following:
- Number of Users:
The estimated number of users for ~~each~~ the majority of waiver services is based on average utilization from WY 18-21, except as noted below.

Community Based Day Supports (CBDS) and Individual Support and Community Habilitation utilization was based on WY 21 because there was not consistent utilization across all four years.

Day Services-Partial Day utilization was based on WY 21 as authorized through Appendix K authority.

Community Support and Navigation and Orientation and Mobility Services utilization was based on utilization in the MFP-CL Waiver because there was no utilization in this waiver.

Home Accessibility Adaptations and Residential Family Training were estimated at one user per year.

Assistive Technology – evaluation and training and device utilization was based on the DDS Adult ID Waiver, with 2% utilization in WY1 and an additional 2% for each of the other waiver years.

~~Community Based Day Supports (CBDS) and Community Behavioral Health Support and Navigation, is based on actual utilization data for the MFP-RS waiver in prior waiver years. For most services, service utilization was based on the averages experienced in waiver years 2015-2017, with estimates for Specialized Medical Equipment based only on waiver year 2017 to reflect the increased utilization of this service. Utilization of CBDS was estimated at 10% of the enrolled population in waiver year 1, 20% in waiver year 2 and 30% in waiver years three through five, based on information provided by Waiver Case Managers and feedback from potential providers of CBDS. Utilization of CBHSN was estimated at 5% of the enrolled population for waiver year 1 and 10% for waiver years two through five, based on consultation with state agency program staff. This estimate was based on review of past utilization of similar services, anticipated need and programmatic goals to provide expanded support of behavioral health needs for the waiver population.~~

- Average Units per User:
The average units per user for ~~all~~ the majority of waiver services is based on average utilization from WY 18-21, except as noted below.

Community Based Day Supports (CBDS) and Individual Support and Community Habilitation utilization was based on WY 21 because there was not consistent utilization across all four years.

Day Services-Partial Day utilization was based on WY 21 as authorized through Appendix K authority.

Community Support and Navigation, Orientation and Mobility Services, and Residential Family Training utilization was based on utilization in the MFP-CL Waiver because there was no utilization in this waiver.

Home Accessibility Adaptations was estimated at one unit per user.

Assistive Technology - evaluation and training and device units per user were based on utilization in the DDS Adult ID waivers.

~~CBDS, Day Services, and Community Behavioral Health Support and Navigation are based on actual utilization for the MFP-RS waiver in waiver years 2015-2017.Average units per user for CBDS was estimated at 18 hours per week, based on information provided by Waiver Case Managers and feedback from potential providers of CBDS. Day service units were reduced to 80% of past utilization to account for some participants selecting CBDS for some or all of their day services. Average units of Day services were estimated at 80% of prior utilization as participants were estimated to substitute some units of Day services with the newly available CBDS service. Average units per user for CBHSN was estimated at 10 hours per week, based on consultation with state agency program staff. This estimate was based on review of past utilization of similar services, anticipated need and programmatic goals to provide expanded support of behavioral health needs for the waiver population.~~

- Average Cost per Unit: The average cost per unit is based on rates established in 101 CMR 359.00 Rates for Home and Community Based Services Waivers. For services with multiple rates the unit rate reflects a blended average of the actual rates for these services in ~~years 2015-2017~~WY 21. For services with no historical utilization in this waiver, the rate was based on the blended average rate from the MFP-CL waiver. For Residential Habilitation the provisional rate for FY22 was utilized.

Day Services-Partial Day rate is based on WY 21 as authorized through Appendix K authority.

Assistive Technology - evaluation and training and device rates were based on DDS Adult ID Waiver rates.

~~For CBDS the average cost per unit is estimated at a blended average of the anticipated rate for this service. The average cost per unit for Home Accessibility Adaptations and Transitional Assistance are based on claims data from waiver years 2015-2017. The average cost per unit for Community Behavioral Health Support and Navigation is based on rates for similar 1915(c) waiver services in Massachusetts.~~

- Trend: Average costs per unit described above are trended forward by 3.~~8~~2% annually, beginning in Waiver Year ~~2~~1, based on the Medical Consumer Price Index (CPI) for the first six months of calendar year 2022~~16~~.

ii. Factor D′ Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' costs are based on a weighted average annualized cost from WY 20~~waiver years 2015-2017~~. The annualized value of Factor D' ~~($28,263.82)~~ is adjusted by the average length of stay used for Factor D to make the period of comparison comparable (i.e., the annualized value of Factor D' for each waiver year was multiplied by the average length of stay [ALOS] for that waiver year and divided by 365).

The weighted average cost from WY 20~~waiver years 2015-2017~~ was ~~utilized as the base for 2018 and then~~ trended forward by 3.2~~8~~% annually, based on the Medical Consumer Price Index (CPI) for the first six months of calendar year 2022~~16~~ (according to BLS CPI-All Urban Consumers, US City Average, Medical Care, 2022~~16~~ Calendar Year average of ~~all 12~~ the first six months).

In summary, the WY1 baseline estimate for Factor D' is calculated as follows:

D' = [Average Annualized D' x (WY 1 ALOS ÷ 365)] x 1.032~~8~~

As Factor D' costs are based on ~~waiver year 2015-2017~~WY 20 data, the cost and utilization of prescription drugs in the base data reflects the full implementation of Medicare Part D. Therefore no Medicare Part D drug costs or utilization are included in the Factor D' estimate.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The comparable facility population is based on MassHealth members residing in a nursing home or chronic/rehabilitation hospital for 180 or more consecutive days (only 1 day of the stay need have occurred in the current waiver year.) The facility population is separated into two subgroups, Nursing Facility or Chronic/Rehabilitation Hospital.

Factor G is derived from a weighted average (based on the expected proportion of waiver participants at each level of care over the 5 year waiver period as indicated in Appendix J-2-a) of Waiver Year 2020~~16~~ annualized actual average cost per member per year for a comparable population. ~~in a:~~
~~- continuous nursing facility (Annualized G = $191,590.16; ALOS = 331.82); or~~
~~- chronic rehabilitation hospital stay (Annualized G = $249,652.81; ALOS = 340.68).~~

Factor G costs are trended forward from the base year of 2020~~18~~ by 3.~~8~~2% annually, based on the Medical Consumer Price Index for the first six months of calendar year 2022~~016~~ (according to BLS CPI-All Urban Consumers, US City Average, Medical Care, 2022~~016~~ Calendar Year average of ~~all 12~~ the first six months). The annualized value of Factor G is adjusted by the average length of stay used for Factor D to make the period of comparison comparable (i.e., the annualized value of Factor G for each waiver year was multiplied by the average length of stay [ALOS] for that waiver year and divided by 365).

In summary, the WY1 baseline estimate for Factor G is calculated as follows:

G = 1.03~~8~~ x [((% of Waiver Population at Nursing Facility LOC x Nursing Facility Annualized G) + (% of Waiver Population at Hospital LOC x Hospital Annualized G)) x WY1 Factor D ALOS ÷ 365]

iv. Factor G′ Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The comparable facility population is based on MassHealth members residing in a nursing home or chronic/rehabilitation hospital for 180 or more consecutive days (only 1 day of the stay need have occurred in the current waiver year.) The facility population is separated into two subgroups, Nursing Facility or Chronic/Rehabilitation Hospital.

Factor G' is derived from a weighted average (based on the expected proportion of waiver participants at each level of care over the 5 year waiver period as indicated in Appendix J-2-a) of Waiver Year 2020~~16~~ annualized actual average cost per member per year for non-facility Medicaid State Plan costs for a comparable population. ~~in a:~~
~~- continuous nursing facility (Annualized G' = $18,017.49; ALOS = 331.82); or~~
~~- chronic rehabilitation hospital stay (Annualized G' = $5,938.48; ALOS = 340.68).~~

Factor G' costs are trended forward from the base year of 2020~~18~~ by 3.~~8~~2% annually, based on the Medical Consumer Price Index for the first six months of calendar year 2022~~16~~ (according to BLS CPI-All Urban Consumers, US City Average, Medical Care, 2022~~16~~ Calendar Year

average of the first six ~~all 12~~ months). The annualized value of Factor G' is adjusted by the average length of stay used for Factor D to make the period of comparison comparable (i.e., the annualized value of Factor G' for each waiver year was multiplied by the average length of stay [ALOS] for that waiver year and divided by 365).

In summary, the WY1 baseline estimate for Factor G' is calculated as follows:

G' = 1.03~~28~~ x [((% of Waiver Population at Nursing Facility LOC x Nursing Facility Annualized G') + (% of Waiver Population at Hospital LOC x Hospital Annualized G')) x WY1 Factor D ALOS ÷ 365]

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services
Prevocational Services
Residential Habilitation
Supported Employment
Assisted Living Services
Assistive Technology
Community Based Day Supports
Community Behavioral Health Support and Navigation
Day Services
Home Accessibility Adaptations
Individual Support and Community Habilitation
Occupational Therapy
Orientation and Mobility Services
Peer Support
Physical Therapy
Residential Family Training
Shared Living – 24 Hour Supports
Skilled Nursing
Specialized Medical Equipment
Speech Therapy
Transitional Assistance Services
Transportation

d. Estimate of Factor D.

i. Estimate of Factor D – Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Prevocational Services	15 min.	58~~24~~	852~~615.00~~	$12.07 ~~9.15~~	$596,451.12 ~~135054.00~~
Residential Habilitation	Per Diem	535~~328~~	302~~320.00~~	$620.07 ~~504.46~~	$100,184,709.90 ~~52948121.60~~
Supported Employment	15 min.	42~~33~~	545~~350.00~~	$17.35 ~~9.15~~	$397,141.50 ~~105682.50~~
Assisted Living Services	Per Diem	12~~18~~	239~~320.00~~	$109.29 ~~104.53~~	$313,443.72 ~~602092.80~~
Assistive Technology Total:					$38,871.96
Assistive Technology – devices	Item	12	5	$290.62	$17,437.20
Assistive Technology – evaluation and training	15 min.	12	89	$20.07	$21,434.76
Community Based Day Supports	15 min.	105~~36~~	160~~3282.00~~	$4.90 ~~5.16~~	$82,320.00 ~~609664.32~~
Community Behavioral Health Support and Navigation	15 min.	2~~18~~	43~~1823.00~~	$11.62 ~~10.91~~	$999.32 ~~358000.74~~
Day Services Total:					~~1616353.20~~
Day Services	Per Diem	206~~154~~	104~~102.00~~	$135.99 ~~102.90~~	$2,913,449.76
Day Services	Partial Per Diem	75	60	$72.57	$326,565.00
Home Accessibility Adaptations	Item	1~~4~~	1~~1.00~~	$5,245.46 ~~5730.57~~	$5,245.46 ~~22922.28~~
Individual Support and Community Habilitation	15 min.	3~~7~~	24~~401.00~~	$6.38 ~~10.91~~	$459.36 ~~30624.37~~
Occupational Therapy	Visit	353~~58~~	40~~57.00~~	$77.77 ~~71.20~~	$1,098,112.40 ~~235387.20~~
Orientation and Mobility Services	15 min.	1~~4~~	38~~14.00~~	$41.51 ~~31.02~~	$1,577.38 ~~1737.12~~
Peer Support	15 min.	137~~34~~	1,409~~2109.00~~	$7.83 ~~6.49~~	$1,511,448.39 ~~465371.94~~
Physical Therapy	Visit	279~~68~~	53~~61.00~~	$74.55 ~~68.30~~	$1,102,370.85 ~~283308.40~~
Residential Family Training	15 min.	1~~7~~	175~~207.00~~	$6.78 ~~6.49~~	$1,186.50 ~~9404.01~~

Waiver Year: Year 1					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Shared Living – 24 Hour Supports	Per Diem	37~~18~~	326~~320.00~~	$254.57 ~~211.49~~	$3,070,623.34 ~~1218182.40~~
Skilled Nursing	Visit	14~~11~~	30~~182.00~~	$94.49 ~~86.99~~	$39,685.80 ~~174153.98~~
Specialized Medical Equipment	Item	408~~217~~	7~~6.00~~	$366.40 ~~300.06~~	$1,046,438.40 ~~390678.12~~
Speech Therapy	Visit	48~~30~~	52~~65.00~~	$79.72 ~~72.88~~	$198,981.12 ~~141216.00~~
Transitional Assistance Services	Per Episode	90~~60~~	2~~2.00~~	$1,961.61 ~~1028.75~~	$353,089.80 ~~123450.00~~
Transportation	1 Way Trip	192~~157~~	156~~247.00~~	$96.49 ~~40.10~~	$2,890,068.48 ~~1555037.90~~
GRAND TOTAL:					$116,173,239.56 ~~39367032.27~~
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					624~~843~~
FACTOR D (Divide grand total by number of participants)					$186,175.06 ~~46698.73~~
AVERAGE LENGTH OF STAY ON THE WAIVER					323.60~~298~~

Waiver Year: Year 2					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Prevocational Services	15 min.	6228	852622.00	$12.46 9.50	$658,187.04 164542.00
Residential Habilitation	Per Diem	578377	302324.00	$639.91 523.63	$111,700,129.96 63960357.24
Supported Employment	15 min.	4538	545354.00	$17.91 9.50	$439,242.75 127794.00
Assisted Living	Per Diem	1321	239324.00	$112.79 108.50	$350,438.53 738234.00
Assistive Technology Total:					$90,255.33
Assistive Technology – devices	Item	27	5	$299.92	$40,489.20
Assistive Technology – evaluation and training	15 min.	27	89	$20.71	$49,766.13
Community Based Day Supports	15 min.	11485	1603322.00	$5.06 5.36	$92,294.40 1513503.20
Community Behavioral Health Support and Navigation	15 min.	242	431846.00	$11.99 11.32	$1,031.14 877662.24
Day Services Total:					$3,604,135.32 1738225.94
Day Services	Per Diem	222158	104103.00	$140.34 106.81	$3,240,169.92
Partial Per Diem	Partial Per Diem	81	60	$74.89	$363,965.40
Home Accessibility Adaptations	Item	14	11.00	$5,413.31 5948.33	$5,413.31 23793.32
Individual Support and Community Habilitation	15 min.	48	24406.00	$6.58 11.32	$631.68 36767.36
Occupational Therapy	Visit	38168	4058.00	$80.26 73.91	$1,223,162.40 291501.04
Orientation and Mobility Services	15 min.	14	3814.00	$42.84 32.20	$1,627.92 1803.20
Peer Support	15 min.	14839	1,4095135.00	$8.08 6.74	$1,684,938.56 561206.10
Physical Therapy	Visit	30280	5362.00	$76.94 70.90	$1,231,501.64 351664.00
Residential Family Training	15 min.	18	175210.00	$7.00 6.74	$1,225.00 11323.20
Shared Living – 24 Hour Support	Per Diem	4025	326324.00	$262.72 219.53	$3,425,868.80 1778193.00
Skilled Nursing	Visit	1513	30184.00	$97.51 90.30	$43,879.50 215997.60
Specialized Medical Equipment	Item	440253	76.00	$378.12 311.46	$1,164,609.60 472796.28

Waiver Year: Year 2					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Speech Therapy	Visit	52~~35~~	52~~66.00~~	$82.27 ~~75.65~~	$222,458.08 ~~174751.50~~
Transitional Assistance Services	Per Episode	98~~60~~	2~~2.00~~	$2,024.38 ~~1067.84~~	$396,778.48 ~~128140.80~~
Transportation	1 Way Trip	207~~183~~	156~~250.00~~	$99.58 ~~41.62~~	$3,215,637.36 ~~1904115.00~~
GRAND TOTAL:					$129,553,446.80 ~~75073281.02~~
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					674~~424~~
FACTOR D (Divide grand total by number of participants)					$192,215.80 ~~177059.63~~
AVERAGE LENGTH OF STAY ON THE WAIVER					324~~324~~

Waiver Year: Year 3					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Prevocational Services	15 min.	6732	852628.00	$12.86 9.86	$734,100.24 198146.56
Residential Habilitation	Per Diem	621426	302327.00	$660.39 543.53	$123,850,861.38 75714816.06
Supported Employment	15 min.	4944	545358.00	$18.48 9.86	$493,508.40 155314.72
Assisted Living Services	Per Diem	1424	239327.00	$116.40 112.62	$389,474.40 883841.76
Assistive Technology Total:					$148,329.79
Assistive Technology – devices	Item	43	5	$309.52	$66,546.80
Assistive Technology – evaluation and training	15 min.	43	89	$21.37	$81,782.99
Community Based Day Supports	15 min.	122145	1603353.00	$5.22 5.56	$101,894.40 2703188.60
Community Behavioral Health Support and Navigation	15 min.	248	431863.00	$12.37 11.75	$1,063.82 1050732.00
Day Services Total:					$4,003,348.28 1798754.88
Day Services	Per Diem	239156	104104.00	$144.83 110.87	$3,599,894.48
Partial Per Diem	Partial Per Diem	87	60	$77.29	$403,453.80
Home Accessibility Adaptations	Item	15	11.00	$5,586.54 6174.37	$5,586.54 30871.85
Individual Support and Community Habilitation	15 min.	410	24410.00	$6.79 11.75	$651.84 48175.00
Occupational Therapy	Visit	40977	4058.00	$82.83 76.72	$1,355,098.80 342631.52
Orientation and Mobility Services	15 min.	15	3814.00	$44.21 33.42	$1,679.98 2339.40
Peer Support	15 min.	15945	1,4092154.00	$8.34 7.00	$1,868,418.54 678510.00
Physical Therapy	Visit	32491	5362.00	$79.40 73.59	$1,363,456.80 415194.78
Residential Family Training	15 min.	110	175212.00	$7.22 7.00	$1,263.50 14840.00
Shared Living – 24 Hour Supports	Per Diem	4334	326327.00	$271.13 227.87	$3,800,700.34 2533458.66
Skilled Nursing	Visit	1715	30186.00	$100.63 93.73	$51,321.30 261506.70
Specialized Medical Equipment	Item	473289	77.00	$390.22 323.30	$1,292,018.42 654035.90

Waiver Year: Year 3					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Speech Therapy	Visit	56~~40~~	52~~66.00~~	$84.90 ~~78.52~~	$247,228.80 ~~207292.80~~
Transitional Assistance Services	Per Episode	105~~60~~	2~~2.00~~	$2,089.16 ~~1108.42~~	$438,723.60 ~~133010.40~~
Transportation	1 Way Trip	222~~208~~	156~~252.00~~	$102.77 ~~43.20~~	$3,559,130.64 ~~2264371.20~~
GRAND TOTAL:					$143,707,859.81 ~~90091032.79~~
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					724~~484~~
FACTOR D (Divide grand total by number of participants)					$198,491.52 ~~186138.50~~
AVERAGE LENGTH OF STAY ON THE WAIVER					324~~327~~

Waiver Year: Year 4 *(only appears if applicable based on Item 1-C)*					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Prevocational Services	15 min.	7235	852641.00	$13.27 10.23	$814,034.88 229510.05
Residential Habilitation	Per Diem	664446	302333.00	$681.52 564.18	$136,663,842.56 87548324.04
Supported Employment	15 min.	5248	545365.00	$19.07 10.23	$540,443.80 179229.60
Assisted Living Services	Per Diem	1426	239333.00	$120.12 116.90	$401,921.52 1012120.20
Assistive Technology Total:					$220,692.10
Assistive Technology – devices	Item	62	5	$319.42	$99,020.20
Assistive Technology – evaluation and training	15 min.	62	89	$22.05	$121,671.90
Community Based Day Supports	15 min.	131159	1603420.00	$5.39 5.77	$112,974.40 3137610.60
Community Behavioral Health Support and Navigation	15 min.	253	431900.00	$12.77 12.20	$1,098.22 1228540.00
Day Services Total:					$4,403,954.40 2085940.08
Day Services	Per Diem	255171	104106.00	$149.46 115.08	$3,963,679.20
Partial Per Diem	Partial Per Diem	92	60	$79.76	$440,275.20
Home Accessibility Adaptations	Item	15	11.00	$5,765.31 6409.00	$5,765.31 32045.00
Individual Support and Community Habilitation	15 min.	411	24418.00	$7.01 12.20	$672.96 56095.60
Occupational Therapy	Visit	43884	4060.00	$85.48 79.64	$1,497,609.60 401385.60
Orientation and Mobility Services	15 min.	15	3815.00	$45.62 34.69	$1,733.56 2601.75
Peer Support	15 min.	17049	1,4092197.00	$8.61 7.27	$2,062,353.30 782637.31
Physical Therapy	Visit	34799	5364.00	$81.94 76.39	$1,506,958.54 484007.04
Residential Family Training	15 min.	111	175216.00	$7.45 7.27	$1,303.75 17273.52
Shared Living – 24 Hour Supports	Per Diem	4637	326333.00	$279.81 236.53	$4,196,030.76 2914286.13
Skilled Nursing	Visit	1816	30189.00	$103.85 97.29	$56,079.00 294204.96
Specialized Medical Equipment	Item	506316	77.00	$402.71 335.59	$1,426,398.82 742325.08

Waiver Year: Year 4 *(only appears if applicable based on Item 1-C)*					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Speech Therapy	Visit	6044	5268.00	$87.62 81.50	$273,374.40 243848.00
Transitional Assistance Services	Per Episode	11245	22.00	$2,156.01 1150.54	$482,946.24 103548.60
Transportation	1 Way Trip	238228	156257.00	$106.06 44.84	$3,937,795.68 2627444.64
GRAND TOTAL:					$158,607,983.80 104122977.80
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					774529
FACTOR D (Divide grand total by number of participants)					$204,919.88 196829.83
AVERAGE LENGTH OF STAY ON THE WAIVER					324333

Waiver Year: Year 5 *(only appears if applicable based on Item 1-C)*					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Prevocational Services	15 min.	7638	852643.00	$13.69 10.62	$886,454.88 259489.08
Residential Habilitation	Per Diem	707505	302335.00	$703.33 585.62	$150,170,801.62 99072263.50
Supported Employment	15 min.	5652	545366.00	$19.68 10.62	$600,633.60 202119.84
Assisted Living Services	Per Diem	1529	239335.00	$123.96 121.34	$444,396.60 1178818.10
Assistive Technology Total:					$301,254.88
Assistive Technology – devices	Item	82	5	$329.64	$135,152.40
Assistive Technology – evaluation and training	15 min.	82	89	$22.76	$166,102.48
Community Based Day Supports	15 min.	139172	1603431.00	$5.56 5.99	$123,654.40 3534890.68
Community Behavioral Health Support and Navigation	15 min.	257	431906.00	$13.18 12.66	$1,133.48 1375407.72
Day Services Total:					$4,847,123.92 2364512.75
Day Services	Per Diem	272185	104107.00	$154.24 119.45	$4,363,141.12 2364512.75
Partial Per Diem	Partial Per Diem	98	60	$82.31	$483,982.80
Home Accessibility Adaptation	Item	16	11.00	$5,949.80 6652.54	$5,949.80 39915.24
Individual Support and Community Habilitation	15 min.	411	24419.00	$7.23 12.66	$694.08 58349.94
Occupational Therapy	Visit	46692	4060.00	$88.22 82.67	$1,644,420.80 456338.40
Orientation and Mobility Services	15 min.	16	3815.00	$47.08 36.01	$1,789.04 3240.90
Peer Support	15 min.	18153	1,4092205.00	$8.89 7.55	$2,267,207.81 882330.75
Physical Therapy	Visit	369108	5364.00	$84.56 79.29	$1,653,739.92 548052.48
Residential Family Training	15 min.	111	175217.00	$7.69 7.55	$1,345.75 18021.85
Shared Living - 24 Hour Supports	Per Diem	4940	326335.00	$288.76 245.52	$4,612,652.24 3289968.00
Skilled Nursing	Visit	1917	30190.00	$107.17 100.99	$61,086.90 326197.70
Specialized Medical Equipment	Item	538343	77.00	$415.60 348.34	$1,565,149.60 836364.34

Waiver Year: Year 5 *(only appears if applicable based on Item 1-C)*					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Speech Therapy	Visit	6448	5268.00	$90.42 84.60	$300,917.76 276134.40
Transitional Assistance Services	Per Episode	11945	22.00	$2,225.00 1194.26	$529,550.00 107483.40
Transportation	1 Way Trip	253247	156258.00	$109.45 46.54	$4,319,772.60 2965808.04
GRAND TOTAL:					$174,339,729.68 117795707.11
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					824574
FACTOR D (Divide grand total by number of participants)					$211,577.34 205219.00
AVERAGE LENGTH OF STAY ON THE WAIVER					324335